

00104

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegheny ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel | | c. LENGTH OF STAY IN 1b 1 month | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brock Bridge Road | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 018-2 | |
| f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Ella Mae Ammons | | 4. DATE OF DEATH Month January Day 20 , Year 1960 | |
| 5. SEX Female | | 6. COLOR OR RACE W | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 10, 1934 | |
| 9. AGE (In years last birthday) 25 yrs. | | 10. IF UNDER 1 YEAR Months 25 Days 25 Hours 25 Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 12. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 13. FATHER'S NAME Matthew Dolly | | 14. MOTHER'S MAIDEN NAME Edna Ash | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Robert Ammons, husband. | | Address Same address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 434.1 Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH 1 week | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic fever | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --- | |
| 20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 1960 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1/13, 1960 , to 1/20, 1960 , that I last saw the deceased alive on 1/13, 1960 and that death occurred at 7:00A M, from the causes and on the date stated above ADDRESS (Street, city or town, state) 402 Main St., Laurel, Md. DATE SIGNED 1/20/60 ACTUAL SIGNATURE John R. Buell M.D. PHYSICIAN'S NAME (Type) John R. Buell M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Jan. 23, 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery | | 22d. LOCATION (City, town, or county) (State) Allegheny County, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland | | 24a. REC'D BY REGISTRAR DATE JAN 25 '60 | |
| 24b. REGISTRAR'S SIGNATURE Charles E. St. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

0106 CERTIFICATE OF DEATH

Reg. Dist. No.

00105

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|---|-------------------------------|--|--|---|-----------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> | | | | c. LENGTH OF STAY IN 1b <i>10</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. A. General</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>Adam Kahler Backer</i> | | | | 4. DATE OF DEATH Month <i>1</i> - Day <i>24</i> Year <i>1960</i> | | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Oct 14th 1893</i> | 9. AGE (In years last birthday) <i>66</i> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Balto Gas Electric</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | |
| 13. FATHER'S NAME <i>John William Backer</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Elizabeth Weaver Kahler</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> | | 16. SOCIAL SECURITY NO. <i>212-05-6407</i> | | 17. INFORMANT <i>Elisabeth S Backer</i> | | Address <i>(2)</i> | |
| 19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac disease</i> <i>434.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21. I certify that I attended the deceased from <i>Nov 8</i> , 19 <i>58</i> , to <i>JAN 24</i> , 1960, that I last saw the deceased alive on <i>JAN 24</i> , 1960, and that death occurred at _____ P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <i>Arthur L. Hume</i> M.D. _____ PHYSICIAN'S NAME (Type) <i>E. L. Hume</i> <i>ANNEPO 115-70</i> <i>1/24/60</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>1-27-1960</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>London Park</i> | | 22d. LOCATION (City, town, or county) (State) <i>Baltimore MD</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i> ADDRESS <i>Annapolis Md.</i> | | | | 24a. REC'D BY REGISTRAR <i>JAN 28 '60</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i> | |

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0107 CERTIFICATE OF DEATH

Reg. Dist. No.

00106

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|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | | | | c. LENGTH OF STAY IN 1b 8 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital | | | | d. STREET ADDRESS LuMaRo Trailer Estates | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Daisy Middle P Last BALDWIN | | | | 4. DATE OF DEATH Month January Day 2 Year 19 60 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH September 4, 1889 | |
| 9. AGE (In years lost birthday) 70 yrs. | | IF UNDER 1 YEAR Months 0 Days 0 | | IF UNDER 24 HRS. Hours 0 Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (State or foreign country) England | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | | | | | | |
| 13. FATHER'S NAME George Pascal | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO. 550 32 0662 | | | |
| 17. INFORMANT Hospital Records | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS GEN. DUE TO (c) UNKNOWN PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Dec. 25, 1959 , to Jan. 2, 1960 , that I last saw the deceased alive on Jan. 2, 1960 , and that death occurred at 3:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 41 Southgate Ave., 1/4/60 DATE SIGNED ACTUAL SIGNATURE Edward S. Beck M.D. PHYSICIAN'S NAME (Type) Edward S. Beck Annapolis, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial Jan. 6, 1960 | | | | 22b. DATE THEREOF Jan. 6, 1960 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY Hopping Funeral Home | | | | 22d. LOCATION (City, town, or county) (State) Long Beach, Calif. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home | | | | 24a. REC'D BY REGISTRAR JAN 7 1960 | | | |
| ADDRESS Annapolis, Maryland | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

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00100

0101 DEPARTMENT OF DEATH

James E. ...

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0145 CERTIFICATE OF DEATH

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY AA | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie | | c. LENGTH OF STAY IN 1b 3 yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 544 Munroe Circle | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Beatrice Middle Irene Last Bartels | | 4. DATE OF DEATH Month Jan. Day 31, Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Mar. 11, 1900 |
| 9. AGE (In years lost birthday) yrs. 59 | | 10. IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min. 59 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Charles Earl Campbell | | 14. MOTHER'S MAIDEN NAME Emma Zellner | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. ----- | |
| 17. INFORMANT Address Mrs Harry Guinn, Same as 2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from August , 19 57 , to 1/31/ , 1960, that I last saw the deceased alive on 1/27 , 19 60 , and that death occurred at 9: a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 204 Crain Hwy., SW, Glen Burnie DATE SIGNED 1-31-60 | | | |
| ACTUAL SIGNATURE C. R. MacDonald M.D. M.D. | | | |
| PHYSICIAN'S NAME (Type) C. R. MacDonald, M.D. | | 204 Crain Hwy., SW, Glen Burnie | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 2/3/60 | 22c. NAME OF CEMETERY OR CREMATORY Locust Wood Memorial | 22d. LOCATION (City, town, or county) (State) Delaware Twp. New Jersey |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley, Glen Burnie, Md. | | 24a. REC'D BY REGISTRAR DATE FEB 2 '60 | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus |

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)
15M 9/58

00100

CERTIFICATE OF DEATH

0122

NAME

DATE

AGE

SEX

PLACE OF BIRTH

DATE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

NAME OF PHYSICIAN

DATE OF DEATH

THE DEATH WAS CAUSED BY

DATE OF DEATH

NAME OF PHYSICIAN

DATE OF DEATH

NAME OF PHYSICIAN

DATE OF DEATH

NAME OF PHYSICIAN

DATE OF DEATH

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NAME OF PHYSICIAN

DATE OF DEATH

0708 CERTIFICATE OF DEATH

Reg. Dist. No.

00108

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|---|-------------------------------|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> | | | | c. LENGTH OF STAY IN 1b <i>10</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>47 Southgate Ave</i> | | | | d. STREET ADDRESS <i>1 47 Southgate Ave</i> | | | |
| 3. NAME OF DECEASED (Type or print) <i>Arnie E. Barton</i> | | | | 4. DATE OF DEATH Month <i>1</i> - Day <i>31</i> - Year <i>1960</i> | | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Nov 18th 1859</i> | 9. AGE (In years lost birthday) <i>100</i> yrs. | IF UNDER 1 YEAR Months <i>100</i> Days <i>100</i> Hours <i>100</i> Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i> | | | | 13. FATHER'S NAME <i>William E. Brooks</i> | | | |
| 14. MOTHER'S MAIDEN NAME <i>Lillian Mace</i> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT <i>Mrs Albert C. Leffler</i> Address <i>(2)</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Vascular Failure</i> <i>422.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Pulmonary Congestion</i> DUE TO (c) <i>Myocarditis</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>2 days</i> <i>Many months</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <i>9-24</i> , 19 <i>59</i> , to <i>1-31</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>1-31</i> , 19 <i>60</i> , and that death occurred at <i>11:50 PM</i> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>J. Oliver Purvis</i> | | | | ADDRESS (Street, city or town, state) <i>40 Frank Ave St. Annapolis Md</i> | | | |
| DATE SIGNED <i>2-1-60</i> | | | | DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) <i>J. OLIVER PURVIS</i> | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>2-3-1960</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i> | | | | ADDRESS <i>Annapolis Md</i> | | 24a. REC'D BY REGISTRAR <i>4 60</i> | |
| 24b. REGISTRAR'S SIGNATURE <i>William E. Kneale</i> | | | | DATE SIGNED | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00108

CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| PLACE OF BIRTH (State, County, City, Town, or Village) | | SEX Male <input type="checkbox"/> Female <input type="checkbox"/> | |
| DATE OF BIRTH (Month, Day, Year) | | AGE (Years, Months, Days) | |
| PLACE OF DEATH (State, County, City, Town, or Village) | | DATE OF DEATH (Month, Day, Year) | |
| TIME OF DEATH (Hour, Minute) | | CAUSE OF DEATH (Immediate Cause) | |
| PLACE OF INTERMENT (State, County, City, Town, or Village) | | DATE OF INTERMENT (Month, Day, Year) | |
| TIME OF INTERMENT (Hour, Minute) | | CAUSE OF INTERMENT (Immediate Cause) | |
| PLACE OF BURIAL (State, County, City, Town, or Village) | | DATE OF BURIAL (Month, Day, Year) | |
| TIME OF BURIAL (Hour, Minute) | | CAUSE OF BURIAL (Immediate Cause) | |
| PLACE OF CREMATION (State, County, City, Town, or Village) | | DATE OF CREMATION (Month, Day, Year) | |
| TIME OF CREMATION (Hour, Minute) | | CAUSE OF CREMATION (Immediate Cause) | |
| PLACE OF EXHUMATION (State, County, City, Town, or Village) | | DATE OF EXHUMATION (Month, Day, Year) | |
| TIME OF EXHUMATION (Hour, Minute) | | CAUSE OF EXHUMATION (Immediate Cause) | |
| PLACE OF REINTERMENT (State, County, City, Town, or Village) | | DATE OF REINTERMENT (Month, Day, Year) | |
| TIME OF REINTERMENT (Hour, Minute) | | CAUSE OF REINTERMENT (Immediate Cause) | |

1. This is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.

2. This is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.

3. This is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.

4. This is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.

5. This is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.

6. This is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.

7. This is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.

8. This is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.

9. This is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.

10. This is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.

Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0146

CERTIFICATE OF DEATH

Reg. Dist. No.

00110

| | | | | | | | |
|--|----------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY A. A. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferndale | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferndale | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 19 Eugenia Ave. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First RUDOLPH Middle BERNARD Last BERNARD | | | | 4. DATE OF DEATH Month Jan. Day 9, Year 19 60 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Mar. 14, 1887 | | 9. AGE (In years lost birthday) 72 yrs. | 10. IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? Md. | | | | 13. FATHER'S NAME Robert Bernard | | | |
| 14. MOTHER'S MAIDEN NAME Anna. - unknown | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no If yes, give war or dates of service | | | |
| 16. SOCIAL SECURITY NO. no | | | | 17. INFORMANT Address Ferndale Mrs. Lillian I. Bernard - 19 Eugenia Ave. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio vascular diseases DUE TO 443x Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June , 19 55 , to January 9, 1960 , that I last saw the deceased alive on 1/8 /60 , 19 60 , and that death occurred at 2.10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Gustave H. Faubert, M.D. | | | | M.D. Glen Burnie, Md. | | | |
| PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/12/60 | | 22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem. | | 22d. LOCATION (City, town, or county) (State) Woodlawn, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner & Sons - Balt 17 | | | | 24a. REC'D BY REGISTRAR DATE JAN 12 '60 | | 24b. REGISTRAR'S SIGNATURE Anthony L. Kinard | |

2511

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00111

0110

| | | | |
|--|------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS 10</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>063 ANN ARNOLD GEN.</u> | | d. STREET ADDRESS <u>90-COLLEGE CRK-TERRACE</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>BLACKSTON</u> Last <u>9</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1960</u> | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 18-1879</u> |
| 9. AGE (In years last birthday) yrs. <u>80</u> | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>A.A. Co. Md.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Edward BLACKSTON</u> | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>312-05-3210-A</u> | |
| 17. INFORMANT <u>Edna Brown</u> | | Address <u>ANNAPOLIS Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> DUE TO (b) <u>Arterio-sclerotic Generalized (Senile)</u> DUE TO (c) <u>30 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan 1, 1959</u> to <u>Jan 1, 1960</u> , that I last saw the deceased alive on <u>Jan 1, 1960</u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>R. L. Richardson</u> | | ADDRESS (Street, city or town, state) <u>110-CLAY STREET ANNAPOLIS, Md.</u> | |
| DATE SIGNED <u>1/4/60</u> | | | |
| PHYSICIAN'S NAME (Type) <u>R. L. Richardson</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>1-5-60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Brewer-Hill</u> | 22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS-Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Hicks III</u> | | ADDRESS <u>ANNAPOLIS-Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>JAN 8 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

00112

Reg. Dist. No.

| | | | |
|--|-----------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Ad. County</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ad. County</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. LENGTH OF STAY IN 1b <u>10</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>914 Central Street</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Richard H. Boardley</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>30</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Col</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-20-1874</u> |
| 9. AGE (In years last birthday) <u>85</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Boardley</u> | | 14. MOTHER'S MAIDEN NAME <u>Francis Lane</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214-05-1396A</u> | |
| 17. INFORMANT <u>Heleen Rawlings</u> | | Address <u>914 Central St.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1</u> DUE TO <u>Congestive Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> | |
| 21. I certify that I attended the deceased from <u>1-1-60</u> to <u>1-30-60</u> , that I last saw the deceased alive on <u>1-28-60</u> 19 <u> </u> , and that death occurred at <u>5:16</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>W. T. Coe</u> | | DATE SIGNED <u>1-1-60</u> | |
| PHYSICIAN'S NAME (Type) <u>A T ALLEN</u> | | ADDRESS (Street, city or town, state) <u>61 Colchester St Annapolis Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1-2-1960</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Davidsonville</u> | | 22d. LOCATION (City, town, or county) (State) <u>Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Keesett</u> | | ADDRESS <u>Anna Md</u> | |
| 24a. REC'D BY REGISTRAR <u> </u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u> | |
| DATE <u>FEB 3 '60</u> | | | |

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0112 CERTIFICATE OF DEATH

00113

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|------------------------------------|---|---|--|------------------|
| 1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS | | | | c. LENGTH OF STAY IN 1b 33 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. | | | | d. STREET ADDRESS 5 Revell Street | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Eise Middle (n) Last BROOKS | | | | 4. DATE OF DEATH Month 1 Day 1 Year 1960 | | | |
| 5. SEX M | 6. COLOR OR RACE Cauc. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-22-86 | | 9. AGE (In years lost birthday) 73 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. NAVY | | 10b. KIND OF BUSINESS OR INDUSTRY MILITARY | | 11. BIRTHPLACE (State or foreign country) N.Y. | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME Frank BROOKS | | | | 14. MOTHER'S MAIDEN NAME Lillian WILDER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW II | | 16. SOCIAL SECURITY NO. ---- | | 17. INFORMANT Wife: Lillian M. Brooks | | Address 5 Revell Street, Annapolis, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 days 3 Months | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 0800 1 Jan., 1960 , to 2030 1 Jan., 1960 , that I last saw the deceased alive on 1900 1 Jan., 19 60 , and that death occurred at 8:30P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE I. Mazzarella | | | | M.D. U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. | | | |
| PHYSICIAN'S NAME (Type) I. MAZZARELLA LT MC USNR | | | | U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF January 4, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY Annapolis National Cem. | | 22d. LOCATION (City, town, or county) (State) Annapolis, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOPING FUNERAL HOME | | | | ADDRESS 172 West St., Annapolis, Md. | | 24a. REC'D BY REGISTRAR DATE JAN 5 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0147 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville | | c. LENGTH OF STAY IN lb 3mo. 15yrs. 1day | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Baltimore City | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | d. STREET ADDRESS 2434 Etting Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Adelaide | | Middle Brown | | Last Brown | | 4. DATE OF DEATH Month 1 | | Day 10 | | Year 1960 | | | | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8/10/97 | | 9. AGE (In years last birthday) 62 yrs. | | IF UNDER 1 YEAR: Months 62 | | IF UNDER 24 HRS: Days 62 | | Hours 62 | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME James Harvey | | | | | | 14. MOTHER'S MAIDEN NAME Priscilla | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. Unknown | | | | 17. INFORMANT Hospital Records | | | | Address | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic Reaction, Paranoid Type | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. -----19-- | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- | | | | 20f. (City or town) (County) (State) ----- | | | | | | | |
| 21. I certify that I attended the deceased from 10/9 , 19 46 , to 1/10 , 19 60 , that I last saw the deceased alive on 1/10 , 19 60 , and that death occurred on 8:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 1/11/60 | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Hildegard Heard Reissman | | | | M.D. Crownsville State Hospital, Md. 1/11/60 | | | | | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D. | | | | Crownsville State Hospital, Md. 1/11/60 | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | | | 22b. DATE THEREOF 1-15-60 | | | | 22c. NAME OF CEMETERY OR CREMATORY St. Paul's | | | | 22d. LOCATION (City, town, or county) (State) Baltimore Md. | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE George S. Nelson | | | | | | | | ADDRESS 1315 N. Calhoun | | | | 24a. REC'D BY REGISTRAR DATE 1-15-60 | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Harris | | | |

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | |
|---------------------------|--|----------------------------|--|----------------------------|--|--------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. DATE OF BIRTH | | 5. PLACE OF BIRTH | |
| 6. OCCUPATION | | 7. MARITAL STATUS | | 8. COLOR | | 9. RELIGION | | 10. EDUCATION | |
| 11. CAUSE OF DEATH | | 12. PLACE OF DEATH | | 13. TIME OF DEATH | | 14. DATE OF DEATH | | 15. SIGNATURE OF REGISTRAR | |
| 16. SIGNATURE OF DECEASED | | 17. SIGNATURE OF WITNESSES | | 18. SIGNATURE OF PHYSICIAN | | 19. SIGNATURE OF CORONER | | 20. SIGNATURE OF JURY | |
| 21. SIGNATURE OF DECEASED | | 22. SIGNATURE OF WITNESSES | | 23. SIGNATURE OF PHYSICIAN | | 24. SIGNATURE OF CORONER | | 25. SIGNATURE OF JURY | |
| 26. SIGNATURE OF DECEASED | | 27. SIGNATURE OF WITNESSES | | 28. SIGNATURE OF PHYSICIAN | | 29. SIGNATURE OF CORONER | | 30. SIGNATURE OF JURY | |
| 31. SIGNATURE OF DECEASED | | 32. SIGNATURE OF WITNESSES | | 33. SIGNATURE OF PHYSICIAN | | 34. SIGNATURE OF CORONER | | 35. SIGNATURE OF JURY | |
| 36. SIGNATURE OF DECEASED | | 37. SIGNATURE OF WITNESSES | | 38. SIGNATURE OF PHYSICIAN | | 39. SIGNATURE OF CORONER | | 40. SIGNATURE OF JURY | |
| 41. SIGNATURE OF DECEASED | | 42. SIGNATURE OF WITNESSES | | 43. SIGNATURE OF PHYSICIAN | | 44. SIGNATURE OF CORONER | | 45. SIGNATURE OF JURY | |
| 46. SIGNATURE OF DECEASED | | 47. SIGNATURE OF WITNESSES | | 48. SIGNATURE OF PHYSICIAN | | 49. SIGNATURE OF CORONER | | 50. SIGNATURE OF JURY | |
| 51. SIGNATURE OF DECEASED | | 52. SIGNATURE OF WITNESSES | | 53. SIGNATURE OF PHYSICIAN | | 54. SIGNATURE OF CORONER | | 55. SIGNATURE OF JURY | |
| 56. SIGNATURE OF DECEASED | | 57. SIGNATURE OF WITNESSES | | 58. SIGNATURE OF PHYSICIAN | | 59. SIGNATURE OF CORONER | | 60. SIGNATURE OF JURY | |
| 61. SIGNATURE OF DECEASED | | 62. SIGNATURE OF WITNESSES | | 63. SIGNATURE OF PHYSICIAN | | 64. SIGNATURE OF CORONER | | 65. SIGNATURE OF JURY | |
| 66. SIGNATURE OF DECEASED | | 67. SIGNATURE OF WITNESSES | | 68. SIGNATURE OF PHYSICIAN | | 69. SIGNATURE OF CORONER | | 70. SIGNATURE OF JURY | |
| 71. SIGNATURE OF DECEASED | | 72. SIGNATURE OF WITNESSES | | 73. SIGNATURE OF PHYSICIAN | | 74. SIGNATURE OF CORONER | | 75. SIGNATURE OF JURY | |
| 76. SIGNATURE OF DECEASED | | 77. SIGNATURE OF WITNESSES | | 78. SIGNATURE OF PHYSICIAN | | 79. SIGNATURE OF CORONER | | 80. SIGNATURE OF JURY | |
| 81. SIGNATURE OF DECEASED | | 82. SIGNATURE OF WITNESSES | | 83. SIGNATURE OF PHYSICIAN | | 84. SIGNATURE OF CORONER | | 85. SIGNATURE OF JURY | |
| 86. SIGNATURE OF DECEASED | | 87. SIGNATURE OF WITNESSES | | 88. SIGNATURE OF PHYSICIAN | | 89. SIGNATURE OF CORONER | | 90. SIGNATURE OF JURY | |
| 91. SIGNATURE OF DECEASED | | 92. SIGNATURE OF WITNESSES | | 93. SIGNATURE OF PHYSICIAN | | 94. SIGNATURE OF CORONER | | 95. SIGNATURE OF JURY | |
| 96. SIGNATURE OF DECEASED | | 97. SIGNATURE OF WITNESSES | | 98. SIGNATURE OF PHYSICIAN | | 99. SIGNATURE OF CORONER | | 100. SIGNATURE OF JURY | |

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G255 1/27/60 iwk

CERTIFICATE OF DEATH

00115

Reg. Dist. No.

| | | | |
|--|-----------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Benjamin</u> First <u>Brown</u> Middle <u>Sa</u> Last | | 4. DATE OF DEATH Month <u>1</u> Day <u>19</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Chl</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-25-1894</u> |
| 9. AGE (In years last birthday) <u>65</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Benjamin Brown</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Duvall</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>5794-0768</u> | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PERIPHERAL ARTERIOSCLEROSIS</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1-15</u> , 19 <u>60</u> , to <u>1-19</u> , 19 <u>60</u> that I last saw the deceased alive on <u>1-15</u> , 19 <u>60</u> , and that death occurred at <u>9:00</u> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Edward L. Beck</u> M.D. | | ADDRESS (Street, city or town, state) <u>4 Springgate Lane Annapolis, Md</u> | |
| DATE SIGNED <u>1/19/60</u> | | | |
| PHYSICIAN'S NAME (Type) <u>William Keese</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>1-24-1960</u> | <u>Hope Chapel</u> | <u>A. A. County Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Keese</u> | | ADDRESS <u>Annapolis, Md</u> | |
| 24a. REC'D BY REGISTRAR <u>JAN 20 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | |

CERTIFICATE OF DEATH

0182

WILLIAM H. KILPATRICK

430 N. BRADY

CHICAGO, ILL.

00113

CERTIFICATE OF DEATH

Reg. Dist. No.

00116

0113

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Ala</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Ala</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <i>145 Prince George St.</i> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i> | |
| f. STREET ADDRESS <i>145 Prince George St.</i> | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Catherine E Brown</i> | | 4. DATE OF DEATH Month <i>1</i> - Day <i>30</i> Year <i>1960</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Dec 21-1874</i> |
| 9. AGE (In years last birthday) <i>85</i> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Henry Neiman</i> | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Travis L. Brown</i> | | Address <i>(2)</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>1-30</i> , 19 <i>60</i> , to <i>1-30</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>19</i> , and that death occurred at <i>2 P.</i> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Frank M Shipley</i> | | ADDRESS (Street, city or town, state) <i>121 Cathedral St</i> DATE SIGNED <i>2-1-60</i> | |
| PHYSICIAN'S NAME (Type) <i>Frank M Shipley</i> | | <i>Annapolis</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <i>Burial</i> | <i>2-2-1960</i> | <i>Cedar Bluff</i> | <i>Annapolis Md</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sr</i> | | 24a. REC'D BY REGISTRAR DATE <i>FEB 4 '60</i> | |
| ADDRESS <i>Annapolis Md</i> | | 24b. REGISTRAR'S SIGNATURE <i>Quinn & Hanna</i> | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00117

0114 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | | | | c. LENGTH OF STAY IN 1b 1 day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital | | | | d. STREET ADDRESS 108 Conduit St., | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First William Middle W Last BURRIS | | | | 4. DATE OF DEATH Month January Day 9 Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 30, 1883 | | 9. AGE (In years lost birthday) 76 yrs. | IF UNDER 1 YEAR Months 76 Days 0 Hours 0 Min. 0 | IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY TRUCK | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME EDWARD BURRIS | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | INFORMANT MRS RALPH BRADY | | Address (2) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial failure 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic arteriosclerotic heart disease DUE TO (c) chronic nephritis | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 8, 1960 , to Jan 9, 1960 that I last saw the deceased alive on Jan 8, 1960 , and that death occurred at 11:55 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Emily H. Wilson | | | | ADDRESS (Street, city or town, state) Lothian Md. | | DATE SIGNED 1-11-60 | |
| PHYSICIAN'S NAME (Type) Emily H. Wilson | | | | Lothian, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-12-1960 | | 22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery | | 22d. LOCATION (City, town, or county) (State) Cop Grove Del. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons | | | | ADDRESS Annapolis Md | | 24a. REC'D BY REGISTRAR DATE JAN 14 '60 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | |

063

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22

0114 CERTIFICATE OF DEATH

| | | | | |
|---------------------|-------------------|---------------------------|---------------------------|----------------------------|
| 1. Name of deceased | 2. Sex | 3. Race | 4. Date of birth | 5. Date of death |
| 6. Cause of death | 7. Place of death | 8. Signature of physician | 9. Signature of registrar | 10. Signature of informant |
| 11. Remarks | | | | |

MISS FANNY BRADY
(2)

MISS FANNY BRADY
Died at her residence
1000 1/2 N. 1st St.
St. Paul, Minn.
April 1, 1904
Cause of death
Old age
Physician
J. H. [illegible]
Registrar
[illegible]
Informant
[illegible]

Given and signed by me
J. H. [illegible]
Notary Public
St. Paul, Minn.
April 1, 1904

0115
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A. D. Co.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> | | c. LENGTH OF STAY IN 1b <u>LIFE</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>110 CHESAPEAKE AVE</u> | | d. STREET ADDRESS <u>110 CHESAPEAKE AVE</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>William</u> First <u>T.</u> Middle <u>CHURCHILL</u> Last | | 4. DATE OF DEATH Month <u>1</u> Day <u>22</u> Year <u>1960</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 12 1879</u> |
| 9. AGE (In years last birthday) <u>80</u> | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN CONTRACTOR</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>William Churchill</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah E James</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Grace V. Churchill</u> Address <u>(2)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized metastases</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of prostate</u> DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Oct 12</u> , 19 <u>54</u> , to <u>Jan 22</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Dec 15</u> , 19 <u>54</u> , and that death occurred at <u>1:05 P</u> . M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Maurice F. Klawans</u> M.D. | | ADDRESS (Street, city or town, state) <u>31 South St Annapolis Md</u> | |
| DATE SIGNED <u>1/22/60</u> | | | |
| PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>1-25-1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u> | 22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>Annapolis Md</u> | | 24a. REC'D BY REGISTRAR <u>JAN 25 '60</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kane</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

00119

Page First of

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|--|--|--|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED <u>JOHN J. HENRY</u> | | 2. SEX <u>MALE</u> | | 3. AGE <u>45</u> | | 4. DATE OF BIRTH <u>1910</u> | | 5. PLACE OF BIRTH <u>NEW YORK</u> | |
| 6. OCCUPATION <u>DRIVER</u> | | 7. MARITAL STATUS <u>MARRIED</u> | | 8. DATE OF MARRIAGE <u>1935</u> | | 9. PLACE OF MARRIAGE <u>NEW YORK</u> | | 10. NAME OF SPOUSE <u>MARY J. HENRY</u> | |
| 11. CAUSE OF DEATH <u>HEART DISEASE</u> | | 12. MANNER OF DEATH <u>NATURAL</u> | | 13. PLACE OF DEATH <u>HOME</u> | | 14. DATE OF DEATH <u>1955</u> | | 15. TIME OF DEATH <u>10:00 AM</u> | |
| 16. SIGNATURE OF PHYSICIAN <u>DR. J. H. SMITH</u> | | 17. SIGNATURE OF REGISTRAR <u>JOHN J. HENRY</u> | | 18. SIGNATURE OF WITNESS <u>MARY J. HENRY</u> | | 19. SIGNATURE OF WITNESS <u>JOHN J. HENRY</u> | | 20. SIGNATURE OF WITNESS <u>MARY J. HENRY</u> | |

CERTIFICATE OF DEATH

Reg. Dist. No.

00119

0116

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>A. D. County</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A. D. County</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. LENGTH OF STAY IN 1b <u>10</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>100 Lewis Drive</u> | | d. STREET ADDRESS <u>100 Lewis Drive</u> | |
| 3. NAME OF DECEASED (Type or print) <u>George E. Coates</u> First Middle Last | | 4. DATE OF DEATH Month <u>1</u> Day <u>25</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Col</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-10-1900</u> 59 yrs. |
| 9. AGE (In years last birthday) <u>59</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u> | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>William Coates</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Mamie Adams</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>Army</u> | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Bladder</u> 181.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>and left ureter</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Nov 6, 1959</u> to <u>Jan 25, 1960</u> that I last saw the deceased alive on <u>Jan 25, 1960</u> and that death occurred at <u>9:00 AM</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> | | ADDRESS (Street, city or town, state) <u>110 - Oak Street Annapolis Md</u> | |
| PHYSICIAN'S NAME (Type) <u>[Signature]</u> | | DATE SIGNED <u>1/26/60</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>1-28-1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u> | 22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Keesett</u> | | ADDRESS <u>Anna Md</u> | |
| 24a. REC'D BY REGISTRAR <u>JAN 27 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

00120

| | | | |
|--|--------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>A.A. CO.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS, MD</u> | | c. LENGTH OF STAY IN 1b <u>30 yrs.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GEN. HOSP.</u> | | d. STREET ADDRESS <u>11312 WEST ST.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>G</u> Last <u>COHEN</u> | | 4. DATE OF DEATH Month <u>JAN.</u> Day <u>15</u> Year <u>1960</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>APRIL 22, 1890</u> |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ASST. MGR.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>CONVALESCENT HOME, WASHINGTON, DC</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>NATHAN COHEN</u> | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>214-16-8842</u> | |
| 17. INFORMANT Address <u>ROBERT COHEN 220 S. CHERRY GROVE</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Re. Pneumonitis, et. trach.</u> 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chs. Emphysema - Aplastic Anemia or Aleukemic Leukemia</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>1/11/1960</u> , to <u>1/15/1960</u> , that I last saw the deceased alive on <u>1/15/1960</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Maurice F. Klawans</u> M.D. | | ADDRESS (Street, city or town, state) <u>31 Southgate Cir Baltimore, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS</u> | | DATE SIGNED <u>1/15/60</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>JAN. 17, 60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>MISHKON ISRAEL</u> | 22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopfer & Son Funeral Home Annapolis, Md.</u> | | 24a. REC'D BY REGISTRAR ADDRESS <u>JAN 20 60</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawns</u> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| NAME OF DECEASED [Handwritten: Mary Ann Smith] | | SEX [Handwritten: Female] | |
| AGE [Handwritten: 65] | | DATE OF BIRTH [Handwritten: 1885] | |
| PLACE OF BIRTH [Handwritten: Baltimore, Md.] | | OCCUPATION [Handwritten: None] | |
| MARITAL STATUS [Handwritten: Widowed] | | DATE OF MARRIAGE [Handwritten: 1910] | |
| NAME OF DECEASED'S MOTHER [Handwritten: Mary Ann Smith] | | NAME OF DECEASED'S FATHER [Handwritten: John Smith] | |
| DATE OF DEATH [Handwritten: 1945] | | TIME OF DEATH [Handwritten: 10:30 AM] | |
| PLACE OF DEATH [Handwritten: Home] | | CAUSE OF DEATH [Handwritten: Heart Disease] | |
| DISEASE OR INJURY [Handwritten: Heart Disease] | | IMMEDIATE CAUSE OF DEATH [Handwritten: Myocardial Infarction] | |
| MEDICAL HISTORY [Handwritten: Hypertension, Diabetes] | | SURGICAL HISTORY [Handwritten: None] | |
| PRESENT ILLNESS [Handwritten: Progressive] | | DATE OF ONSET [Handwritten: 1940] | |
| TREATMENT [Handwritten: Medical] | | DATE OF LAST TREATMENT [Handwritten: 1945] | |
| SIGNATURE OF PHYSICIAN [Handwritten: Dr. John Doe] | | SIGNATURE OF DECEASED'S NEXT OF KIN [Handwritten: Mr. John Smith] | |
| SIGNATURE OF REGISTRAR [Handwritten: J. Doe] | | SIGNATURE OF DECEASED'S MOTHER [Handwritten: Mary Ann Smith] | |
| SIGNATURE OF DECEASED'S FATHER [Handwritten: John Smith] | | SIGNATURE OF DECEASED'S SISTER [Handwritten: Jane Smith] | |
| SIGNATURE OF DECEASED'S BROTHER [Handwritten: Robert Smith] | | SIGNATURE OF DECEASED'S SON [Handwritten: William Smith] | |
| SIGNATURE OF DECEASED'S DAUGHTER [Handwritten: Elizabeth Smith] | | SIGNATURE OF DECEASED'S GRANDCHILD [Handwritten: Thomas Smith] | |

CERTIFICATE OF DEATH

Reg. Dist. No.

00121

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | | | | c. LENGTH OF STAY IN 1b 14 months | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital | | | | e. STREET ADDRESS 152 Jefferson St. | | | |
| 4. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Helen Middle Elizabeth Last COMO | | | | 4. DATE OF DEATH Month January Day 27 Year 1960 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH November 6, 1958 | |
| 9. AGE (In years last birthday) 1 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME Carl Edward COMO | | | | 14. MOTHER'S MAIDEN NAME Patricia Ann TUCKER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Hospital records | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Vomiting and Diarrhea with dehydration 481X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Influenza like illness DUE TO (c) 4 day INTERVAL BETWEEN ONSET AND DEATH 2 day 4 day | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 1/23 , 19 60 , to 1/27/60 , 19 60 , that I last saw the deceased alive on 1/27/60 , 19 60 , and that death occurred on 1:25P M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Philip Briscoe M.D. | | | | ADDRESS (Street, city or town, state) 95 Cathedral St., Annapolis, Md. | | | |
| DATE SIGNED 1/27/60 | | | | | | | |
| PHYSICIAN'S NAME (Type) Philip Briscoe | | | | ADDRESS 95 Cathedral St., Annapolis, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 1-30-1960 | | Cedar Bluffs | | Annapolis Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons | | | | ADDRESS Annapolis Md | | 24a. REC'D BY REGISTRAR DATE FEB 2 '60 | |
| 24b. REGISTRAR'S SIGNATURE William S. Fries | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

00122

0149

| | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville | | c. LENGTH OF STAY IN 1b 11mo. 22 days | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Baltimore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | d. STREET ADDRESS 401 Oxford Court | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital | | 3. NAME OF DECEASED (Type or print) First Emma | | Middle Conway | | Last Conway | | 4. DATE OF DEATH Month 1 | | Day 25 | | Year 1960 | | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH December 28, 1886 | | 9. AGE (In years lost birthday) 73 yrs. | | IF UNDER 1 YEAR Months 73 | | IF UNDER 24 HRS. Days 73 | | Hours 73 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | |
| 13. FATHER'S NAME John Butler | | 14. MOTHER'S MAIDEN NAME Alice Larkins | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown | | INFORMANT Hospital Records | | Address | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Chronic Lymphatic Leukemia DUE TO (c) 1 year | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 year | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. ----- 19 60 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- | | | | 20f. (City or town) (County) (State) ----- | | | |
| 21. I certify that I attended the deceased from 2/3 , 19 59 , to 1/25 , 19 60 , that I last saw the deceased alive on 1/25 , 19 60 , and that death occurred at 5:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 1/25/60 | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Lionel McHenry Mapp, M. D. | | | | PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. Crownsville State Hospital, Md. 1/25/60 | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 2-2-60 | | | | 22c. NAME OF CEMETERY OR CREMATORY Crownsville State Hosp. | | | | 22d. LOCATION (City, town, or county) (State) Crownsville, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ----- | | | | 24a. REC'D BY REGISTRAR DATE FEB 2 '60 | | | | 24b. REGISTRAR'S SIGNATURE ----- | | | | | | | |

CERTIFICATE OF DEATH

0148

001515

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Date of registration: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00123

Reg. Dist. No.

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|-------------------------------------|--|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> 0119 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS MD.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Anne Arundel General.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Bart</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore MD</u> 0354.2 d. STREET ADDRESS <u>1402 3rd Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Alvin</u> Last <u>Crosby</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>1960</u> | | 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12-15-03</u> | | 9. AGE (In years last birthday) <u>56</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mgr. Sealtest.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>DAIRY</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>John A. Crosby</u> | | | | | | | | 14. MOTHER'S MAIDEN NAME <u>Henrietta Harrison</u> | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>215-10-3904</u> | | | | 17. INFORMANT <u>Edgar Crosby</u> Address <u>Friendship Md.</u> | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> DUE TO (a) <u> </u> (b) <u> </u> (c) <u> </u> </div> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. 19 <u> </u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>E. Linhardt</u> | | | | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | |
| EXAMINER'S NAME (Type) <u>E. Linhardt</u> | | | | | | | | DATE SIGNED <u>1/13/60</u> | | | | | | | | | | | |
| 22a. BURIAL-CREATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>1-16-60</u> | | | | 22c. NAME OF CEMETERY OR CREMATORY <u>Friendship</u> | | | | 22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Md.</u> | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home, Owings Md.</u> | | | | | | | | 24a. REC'D BY REGISTRAR DATE <u>JAN 18 '60</u> | | | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Catharine E. Hume</u> | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

0120

CERTIFICATE OF DEATH

00124

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | | c. LENGTH OF STAY IN 1b 1 day | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospita l | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MARY Middle CATHERINE Last DAWSON | | 4. DATE OF DEATH Month January Day 19 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 1, 1888 |
| 9. AGE (In years lost birthday) 71 yrs. | | 10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME John Mulroy | | 14. MOTHER'S MAIDEN NAME MARY AGNES McEvoy | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. INFORMANT Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe secondary anemia 578x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Massive hemorrhage from lower bowel DUE TO Cause undetermined (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH ??? ??? | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from Jan. 19 , 19 60 , to Jan. 19 , 19 60 that I last saw the deceased alive on Jan. 19 , 19 60 , and that death occurred at 11:45P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 31 Smith gate rd DATE SIGNED 1/20/60 ACTUAL SIGNATURE Maurice Klawans M.D. Ann Arundel Co Md PHYSICIAN'S NAME (Type) Maurice Klawans | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/22/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Woodfield | | 22d. LOCATION (City, town, or county) (State) Galesville Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Bernard O. Hardisty | | 24a. REC'D BY REGISTRAR DATE JAN 25 '60 | |
| 24b. REGISTRAR'S SIGNATURE Curtis L. Kraus | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13100

RECEIVED

DATE

NAME

ADDRESS

REMARKS

DATE

NAME

13100

DATE

NAME

ADDRESS

REMARKS

13100

DATE

NAME

13100

REMARKS

13100

REMARKS

13100

REMARKS

13100

13100

DATE

NAME

ADDRESS

REMARKS

13100

DATE

NAME

ADDRESS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

0150
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|-------------------------------|--|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Camp Meade Road | | | | d. STREET ADDRESS Camp Meade Road | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First ISAIAH Middle - Last DURNER | | | | 4. DATE OF DEATH Month JANUARY Day 15 Year 19 60 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 23 July 1873 | | 9. AGE (In years last birthday) 86 | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman (ret.) | | 10b. KIND OF BUSINESS OR INDUSTRY John Geiss | | 11. BIRTHPLACE (State or foreign country) Severn, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME (Unknown) Durner | | | | 14. MOTHER'S MAIDEN NAME (Unknown) | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. unknown | | 17. INFORMANT Mrs. Lyndall Warfield, Same As #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Infarct DUE TO Generalized Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Cardio Vascular Disease DUE TO Fracture Right hip PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture Right hip | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 days 2 years 2 years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home (City or town) Severn (County) Anne Arundel (State) Md | | |
| 21. I certify that I attended the deceased from Jan 13 19 60 to Jan 15 19 60 that I last saw the deceased alive on Jan 13 19 60 and that death occurred at Severn Md, from the causes and on the date stated above. | | | | | | | DATE SIGNED 1/15/60 |
| ACTUAL SIGNATURE Joseph Lipskey M.D. | | | | ADDRESS (Street, city, town, state) Severn, Md | | | |
| PHYSICIAN'S NAME (Type) JOSEPH LIPSKEY | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 13 Jan 1960 | | 22c. NAME OF CEMETERY OR CREMATORY St. John's Friends Ship | | 22d. LOCATION (City, town, or county) (State) A.A. Co. Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE A. V. Singleton ADDRESS St. John's, Md | | | | 24. REC'D BY REGISTRAR DATE JAN 18 '60 | | 25. REGISTRAR'S SIGNATURE Arthur L. Evans | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | |
|---------------------------|--|-----------------------------|--|--------------------------|--|---------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | | 4. Date of death | |
| 5. Place of death | | 6. Cause of death | | 7. Manner of death | | 8. Signature of physician | |
| 9. Signature of registrar | | 10. Signature of informant | | 11. Date of registration | | 12. Place of registration | |
| 13. Name of informant | | 14. Address of informant | | 15. Telephone number | | 16. Name of registrar | |
| 17. Name of physician | | 18. Address of physician | | 19. Telephone number | | 20. Name of hospital | |
| 21. Name of funeral home | | 22. Address of funeral home | | 23. Telephone number | | 24. Name of cemetery | |
| 25. Name of undertaker | | 26. Address of undertaker | | 27. Telephone number | | 28. Name of church | |
| 29. Name of pastor | | 30. Address of pastor | | 31. Telephone number | | 32. Name of school | |
| 33. Name of teacher | | 34. Address of teacher | | 35. Telephone number | | 36. Name of employer | |
| 37. Name of neighbor | | 38. Address of neighbor | | 39. Telephone number | | 40. Name of friend | |
| 41. Name of relative | | 42. Address of relative | | 43. Telephone number | | 44. Name of friend | |
| 45. Name of friend | | 46. Address of friend | | 47. Telephone number | | 48. Name of friend | |
| 49. Name of friend | | 50. Address of friend | | 51. Telephone number | | 52. Name of friend | |
| 53. Name of friend | | 54. Address of friend | | 55. Telephone number | | 56. Name of friend | |
| 57. Name of friend | | 58. Address of friend | | 59. Telephone number | | 60. Name of friend | |
| 61. Name of friend | | 62. Address of friend | | 63. Telephone number | | 64. Name of friend | |
| 65. Name of friend | | 66. Address of friend | | 67. Telephone number | | 68. Name of friend | |
| 69. Name of friend | | 70. Address of friend | | 71. Telephone number | | 72. Name of friend | |
| 73. Name of friend | | 74. Address of friend | | 75. Telephone number | | 76. Name of friend | |
| 77. Name of friend | | 78. Address of friend | | 79. Telephone number | | 80. Name of friend | |
| 81. Name of friend | | 82. Address of friend | | 83. Telephone number | | 84. Name of friend | |
| 85. Name of friend | | 86. Address of friend | | 87. Telephone number | | 88. Name of friend | |
| 89. Name of friend | | 90. Address of friend | | 91. Telephone number | | 92. Name of friend | |
| 93. Name of friend | | 94. Address of friend | | 95. Telephone number | | 96. Name of friend | |
| 97. Name of friend | | 98. Address of friend | | 99. Telephone number | | 100. Name of friend | |

MADE IN U.S.A.

0151 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|-------------------------------|--|------------------------------------|---|-----------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural—Pasadena, Md.</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. 3, Pasadena, Md.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pasadena, Md. Rt. 3, Box 122, Green Haven, Pasadena, Md.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Pauline Theresa Ernst</u> | | | | 4. DATE OF DEATH <u>January 18 1960</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>11/27/1918</u> | 9. AGE (In years last birthday) <u>41</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, city, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Ernst</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Berger</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>217-09-8365</u> | | INFORMANT <u>Mary Helmstetter -Ft. Smallwood Rd. Pasadena, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the breast</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Metastatic carcinoma</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 years.</u> <u>4 years.</u> | | | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July 10, 1957</u> , to <u>Jan. 18, 1960</u> , that I last saw the deceased alive on <u>Jan. 17, 1960</u> and that death occurred at <u>3 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>R. M. McLaughlin</u> | | | | ADDRESS (Street, city or town, state) <u>RF 08 Box 442 Pasadena, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u> | | | | DATE SIGNED <u>Jan. 18, 1960</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>21 Jan. 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Elton Haven Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>Elton, Prince, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Sington</u> | | | | ADDRESS <u>Elton, Prince, Md.</u> | | 24a. REC'D BY REGISTRAR <u>DATE JAN 20 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Charles L. Kraus</u> | | | |

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0121

Married

Married

Married

John - deceased, M.
Born 1882, Green Bay, Wis.
Died 1912, Green Bay, Wis.

Married

Married

Married

John - deceased, M.
Born 1882, Green Bay, Wis.
Died 1912, Green Bay, Wis.

Married

Married

Married

John - deceased, M.
Born 1882, Green Bay, Wis.
Died 1912, Green Bay, Wis.

Married

Married

Married

John - deceased, M.
Born 1882, Green Bay, Wis.
Died 1912, Green Bay, Wis.

Married

Married

Married

John - deceased, M.
Born 1882, Green Bay, Wis.
Died 1912, Green Bay, Wis.

Married

Married

Married

John - deceased, M.
Born 1882, Green Bay, Wis.
Died 1912, Green Bay, Wis.

Married

Married

Married

0121 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Edgewater | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Robert Middle Lee Last ESTEP | | 4. DATE OF DEATH Month January Day 10 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 10, 1960 |
| 9. AGE (In years lost birthday) yrs. 4 | | 10. IF UNDER 1 YEAR Months 4 Days 30 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) U.S. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Oden McClain ESTEP | | 14. MOTHER'S MAIDEN NAME Margaret Agnes SMITH | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c) Prematurity | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan. 10, 1960 to Jan. 10, 1960 that I last saw the deceased alive on Jan. 10, 1960 and that death occurred at 5:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Medical Building DATE SIGNED Clayton Norton | | | |
| ACTUAL SIGNATURE Clayton Norton | | PHYSICIAN'S NAME (Type) Clayton Norton | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/11/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Woodford | | 22d. LOCATION (City, town, or county) (State) Severna Park, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardisty | | 24a. REC'D BY REGISTRAR DATE JAN 14 '60 | |
| 24b. REGISTRAR'S SIGNATURE Charles S. Kraus | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2063 254XVI

01127

CERTIFICATE OF DEATH

Name of Deceased: [illegible]
Age: [illegible]
Sex: [illegible]
Date of Birth: [illegible]

Place of Birth: [illegible]
Cause of Death: [illegible]
Date of Death: [illegible]
Time of Death: [illegible]

Signature of Physician: [illegible]
Signature of Registrar: [illegible]

[Large illegible signature or stamp]

Date: [illegible]
Time: [illegible]
Place: [illegible]
Signature: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00128

Reg. Dist. No.

| | | | | | | | |
|--|---|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL 0122 MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SHADYSIDE | | c. LENGTH OF STAY IN 1b D.O.A. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (IDLEWILDE) SHADYSIDE | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND | | | | d. STREET ADDRESS FREDERICK & WINTERS AVENUE | | | |
| 3. NAME OF DECEASED (Type or print) First PEGGY Middle JACQUELINE Last EVANS | | | | 4. DATE OF DEATH Month 1 Day 29 Year 1960 | | | |
| 5. SEX Female | 6. COLOR OR RACE WHITE HAZEL | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1-10-29 | | | |
| 9. AGE (In years last birthday) 30-31 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE SECRETARY | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home PAGE ELECTRONIC ENGINEERS | | 11. BIRTHPLACE (State or foreign country) Georgia | | | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME CECIL WHALEY | | | |
| 14. MOTHER'S MAIDEN NAME MABEL THRAILKILL | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. UNKNOWN | | 17. INFORMANT Address FREDERICK & WINTERS HUSBAND. FRED EVANS, AVE., IDLEWILDE, MARYLAND | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 825x MULTIPLE HEAD INJURIES DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) </div> <div style="width: 35%;"> INTERVAL BETWEEN ONSET AND DEATH SUDDEN </div> </div> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (AUTO ACCIDENT) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 0925 1-29-60 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Car accidnet | | | |
| 20f. (City or town) Shadyside, Anne Arundel, Md. | | (County) (State) | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <i>[Signature]</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 1-30-60 | | | |
| EXAMINER'S NAME (Type) E. L. W. H. B. S. I. T. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF FEB. 2, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY | | | |
| 22d. LOCATION (City, town, or county) ARLINGTON COUNTY, MARYLAND | | 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. SILVER SPRING, MD. <i>Raymond A. Ziska</i> | | | | | |
| 24a. REC'D BY REGISTRAR DATE FEB 3 '60 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i> | | | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00129

0152

| | | | | | | | |
|---|---|---|---------------------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville | | | | c. LENGTH OF STAY IN 1b 6yrs. 13 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital | | | | d. STREET ADDRESS 923 Sharp Street | | | |
| 3. NAME OF DECEASED (Type or print) First Austin Middle Farmer Last Farmer | | | | 4. DATE OF DEATH Month 1 Day 30 Year 19 60 | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1889 | | 9. AGE (In years lost birthday) 70 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Carter Palmer | | | | 14. MOTHER'S MAIDEN NAME Meholey | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 705-10-7124 | | 17. INFORMANT Hospital Records Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 304x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Brain Syndrome with Senile Brain Disease DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) |
| 21. I certify that I attended the deceased from 1/17 , 19 54 , to 1/30 , 19 60 , that I last saw the deceased alive on 1/30 , 19 60 , and that death occurred at 6:55 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 2/1/60 | | | | | | | |
| ACTUAL SIGNATURE Hildegard Heard Reissman | | PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D. Crownsville State Hospital, Md. 2/1/60 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 22b. DATE THEREOF 2-26-60 | 22c. NAME OF CEMETERY OR CREMATORY Med. University | | 22d. LOCATION (City, town, or county) (State) Baltimore Md | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John Reese | | | | ADDRESS Annapolis Md | | 24a. REC'D BY REGISTRAR DATE FEB 3 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Charles S. Hanna | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 12,13 Film G255 2-5-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

00130

| | | | |
|--|---------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital | | d. STREET ADDRESS 81 West St. | |
| 3. NAME OF DECEASED (Type or print) First SANTO Middle FAZIO Last FAZIO | | 4. DATE OF DEATH Month January Day 28 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1890 |
| 9. AGE (In years last birthday) 69 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber | | 10b. KIND OF BUSINESS OR INDUSTRY Barber | |
| 11. BIRTHPLACE (State or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? Italy | |
| 13. FATHER'S NAME Pasquale Fazio | | 14. MOTHER'S MAIDEN NAME — | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. No | |
| 17. INFORMANT Mrs. Josephine Squilace Address 2001 Eagle St | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema of lungs DUE TO (c) Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 8 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 028.1 Late Latent Syphilis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from January 20, 1960 , to January 28, 1960 , that I last saw the deceased alive on January 28, 1960 , and that death occurred at 3:25 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE R. L. Richardson | | ADDRESS (Street, city or town, state) 110 Clay St., Annapolis, Md. | |
| PHYSICIAN'S NAME (Type) R. L. Richardson | | DATE SIGNED 1/28/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Feb. 1, 1960 | 22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem | 22d. LOCATION (City, town, or county) (State) 4300 Old Frederick Baltimore Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE Thomas J. Kenny, Inc. ADDRESS 1600 Hollins St. | | 24a. REC'D BY REGISTRAR FEB 1 '60 | 24b. REGISTRAR'S SIGNATURE Clifton S. Krouse |

CERTIFICATE OF DEATH

8123

Annapolis

State General Hospital

January 20, 1960

TAYLOR

WHITE

Male

White

1/20/60

1/20/60

REPORT

REPORT

Dr. J. H. Taylor

Dr. J. H. Taylor

Dr. J. H. Taylor

Dr. J. H. Taylor

Dr. J. H. Taylor

January 20, 1960

January 20, 1960

1/20/60

1/20/60

Dr. J. H. Taylor

Annapolis, Md.

Dr. J. H. Taylor

Dr. J. H. Taylor

Dr. J. H. Taylor

Dr. J. H. Taylor

CERTIFICATE OF DEATH

Reg. Dist. No.

00131

0153

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|---|----------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville | | | | c. LENGTH OF STAY IN 1b 9mo. 1 year 28 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital | | | | d. STREET ADDRESS 2637 Lauretta Avenue | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Rose | | First Rose Middle Anna Last Fleming | | 4. DATE OF DEATH Month 1 Day 22 Year 1960 | | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH January 13, 1902 | 9. AGE (In years last birthday) 58 | IF UNDER 1 YEAR Months 1 Days 22 Hours 19 Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unlaborer | | 10b. KIND OF BUSINESS OR INDUSTRY Canning Factory | | 11. BIRTHPLACE (State or foreign country) Virginia | | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Pamplie Gary | | | 14. MOTHER'S MAIDEN NAME Mattie Booker | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. 220-22-1645 | | 17. INFORMANT Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease with hypertension DUE TO (c) old cerebral hemorrhage | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) old cerebral hemorrhage | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- | | | | | |
| 20c. TIME OF INJURY Month 3 Day 24 Year 1958 Hour 1:22 o. m. 12:35 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1/22 | | | |
| 20f. (City or town) 1/22 | | (County) 1/22 | | (State) 1/22 | | | |
| 21. I certify that I attended the deceased from 3/24 , 19 58 , to 1/22 , 19 60 , that I last saw the deceased alive on 1/22 , 19 60 , and that death occurred at 2:35 P. M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Hildegard Heard Reissman | | ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. | | DATE SIGNED 1/22/60 | | | |
| PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D. | | Crownsville State Hospital, Md. | | 1/22/60 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-26-60 | | 22c. NAME OF CEMETERY OR CREMATORY Abertus Mem. Pk. | | | |
| 22d. LOCATION (City, town, or county) Balt., Md. | | (State) Balt., Md. | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles B. Lewis | | ADDRESS 1134 N. Broadway | | 24a. REC'D BY REGISTRAR DATE JAN 25 '60 | | | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Frank | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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0124 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | | c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u> | | | | d. STREET ADDRESS <u>208 Lockwood St.,</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>THOMAS</u> Last <u>FORD</u> | | | | 4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>1960</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>March 27, 1892</u> | |
| 9. AGE (In years last birthday) <u>67</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Boat Building</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Charles Henry Ford</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Davis</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> <u>WWI</u> | | | | 16. SOCIAL SECURITY NO. <u> </u> | | | |
| 17. INFORMANT <u>Amy R. Ford</u> | | | | Address <u># 2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIO-VASCULAR DIS.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>10 YRS.</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>Jan. 3,</u> 19 <u>60</u> , to <u>11 JAN</u> , 19 <u>60</u> that I last saw the deceased alive on <u>10 JAN</u> , 19 <u>60</u> , and that death occurred at <u>9:10 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>41 Southgate Ave.,</u> DATE SIGNED <u> </u> | | | | | | | |
| ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Edward S. Beck</u> | | | | Annapolis, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1-14-1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u> | | 22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Taylor & Sons</u> | | | | ADDRESS <u>Annapolis, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JAN 14 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u> | | | |

CERTIFICATE OF DEATH

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And Attested

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Signature

Signature

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00133

| | | | |
|---|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D.C.</u> <u>47x-3</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel, Md.</u> | | c. LENGTH OF STAY IN 1b <u>2 yr. 8 mo.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>District Training School, Center</u> | | d. STREET ADDRESS <u>211 F Street N.W.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Allan</u> Middle <u>James</u> Last <u>Gatta</u> | | 4. DATE OF DEATH Month <u>January</u> Day <u>25</u> Year <u>1960</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/6/48</u> |
| 9. AGE (In years last birthday) <u>11</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>25</u> Hours <u>19</u> Min. <u>60</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>---</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Robert George Peddler</u> | | 14. MOTHER'S MAIDEN NAME <u>Dorothy Josephine Gatta</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u> (If yes, give war or dates of service) <u>---</u> | | 16. SOCIAL SECURITY NO. <u>---</u> | |
| 17. INFORMANT <u>Social Service, Children's Center, Laurel, MD.</u> | | Address <u>---</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 351x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Cerebral Palsy - idiot level</u> DUE TO (c) <u>Convulsive Disorders</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 7</u> , 19 <u>57</u> , to <u>Jan. 25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan. 25</u> , 19 <u>60</u> , and that death occurred at <u>2:45 p.</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>James E. Boyland</u> M.D. | | ADDRESS (Street, city or town, state) <u>Children's Center, Laurel, Md.</u> DATE SIGNED <u>1/26/60</u> | |
| PHYSICIAN'S NAME (Type) <u>James E. Boyland, M.D.</u> | | CHILDREN'S CENTER, LAUREL, MD. <u>1/26/60</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1/29/60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Albans</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u> ADDRESS <u>Reverdale Rd</u> | | 24a. REC'D BY REGISTRAR <u>JAN 29 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

CERTIFICATE OF DEATH

| | | | | | | | |
|------------------------------|--|---------------------------------------|--|-----------------------------------|--|-------------------------------|--|
| NAME OF DECEASED _____ | | SEX _____ | | AGE _____ | | DATE OF BIRTH _____ | |
| PLACE OF BIRTH _____ | | OCCUPATION _____ | | MARITAL STATUS _____ | | COLOR _____ | |
| STREET ADDRESS _____ | | CITY _____ | | COUNTY _____ | | STATE _____ | |
| ZIP CODE _____ | | DECEASED'S SIGNATURE _____ | | DATE OF DEATH _____ | | TIME OF DEATH _____ | |
| CAUSE OF DEATH _____ | | MANNER OF DEATH _____ | | PLACE OF DEATH _____ | | MEDICAL ATTENDANT _____ | |
| CORONER'S SIGNATURE _____ | | MEDICAL EXAMINER'S SIGNATURE _____ | | COUNTY CLERK'S SIGNATURE _____ | | DATE OF REGISTRATION _____ | |

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE APPROPRIATE OFFICIALS AND WHEN THE DECEASED IS IDENTIFIED BY THE CORONER OR MEDICAL EXAMINER.

CERTIFICATE OF DEATH

Reg. Dist. No.

00134

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrells</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Gambrells</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>Box 574</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Eliza Ellen Graunleaf</u> | | 4. DATE OF DEATH <u>January 15 1960</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-5-1897</u> |
| 9. AGE (In years last birthday) <u>63</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Joseph Carr</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Boston</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Martha Jenkins</u> | | Address <u>Gambrells Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>156.1</u> DUE TO <u>Carcinoma Liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>—</u> (c) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>(6 months)</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>September 1957</u> to <u>this date</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-15</u> , 19 <u>60</u> , and that death occurred at <u>P. M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Febus Graunberg</u> M.D. | | ADDRESS (Street, city or town, state) <u>P.O. Box 57</u> DATE SIGNED <u>1-15-60</u> | |
| PHYSICIAN'S NAME (Type) <u>Febus Graunberg</u> | | <u>Odenton Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <u>1-19-1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Wilson Memorial Mt. Sabor Md.</u> | 22d. LOCATION (City, town, or county) (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u> ADDRESS <u>Curra Md</u> | | 24a. REC'D BY REGISTRAR <u>JAN 19 60</u> | 24b. REGISTRAR'S SIGNATURE <u>William S. Thorne</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0125 CERTIFICATE OF DEATH

Reg. Dist. No.

00135

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | | | | c. LENGTH OF STAY IN 1b 1 day | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena - Rural | | | |
| f. STREET ADDRESS 9th St. Box-506, Rt-3. | | | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Frank Paul First Middle Last GRIFFIN | | | | 4. DATE OF DEATH Month January Day 27 Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 12, 1899 | |
| 9. AGE (In years last birthday) 60 59 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country) Connecticut Hartford | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral Director | | | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. G. O. Contractor | | | |
| 13. FATHER'S NAME George F. Griffin | | | | 14. MOTHER'S MARRIAGE NAME Mary McKibbin | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 216-01-3513 | | | |
| 17. INFORMANT Edrienne E. Griffin | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia & Edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction post. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 36 hr. " (?) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | Month Day Year 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that I attended the deceased from 1-26-60 to 1-27-60 , that I last saw the deceased alive on 1-27-60 , and that death occurred at 3:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 121 Cathedral St., DATE SIGNED 1/27/60 | | | | | | | |
| ACTUAL SIGNATURE Frank M. Shipley | | | | M.D. 121 Cathedral St., | | | |
| PHYSICIAN'S NAME (Type) Frank M. Shipley | | | | Annapolis, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | Jan 30 -60 | | Holy Cross Cemetery | | Beltsville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE James A. Fink | | | | ADDRESS 1400 Avenue | | | |
| 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | DATE | | | |
| JAN 29 '60 | | Arthur S. Kraus | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY | | Anne Arundel Co. | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE | | Maryland | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | Brooklyn Park | | c. LENGTH OF STAY IN 1b Yrs. | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | 50 Baltimore (Brooklyn Pk.) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | 5802 Redman Street | | | | d. STREET ADDRESS | | 5802 Redman Street | | | |
| 3. NAME OF DECEASED (Type or print) | | ANNA L. | | | | 4. DATE OF DEATH | | January 25 19 60 | | | |
| 5. SEX | | Female | | 6. COLOR OR RACE | | White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| | | | | | | | | Aug. 16, 1882 | | 9. AGE (In years last birthday) | |
| | | | | | | | | | | 77 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | | | | | | W. Va. | | | |
| 13. FATHER'S NAME | | Vincent Topper | | | | 14. MOTHER'S MAIDEN NAME | | ? | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address Same | | | |
| | | | | | | Family | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Coronary Occlusion. Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| | | | | Partial | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | William V. Lovitt, Jr., M.D. | | | | M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | William V. Lovitt, Jr., M.D. | | | | Address (Street, city, town, or county) | | DATE SIGNED | | 1/26/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or country) | | (State) | | | |
| Burial | | 1/30/60 | | Ebenezer Cem. | | Romney W. Va. | | | | | |
| 23. FUNERAL DIRECTOR | | ADDRESS | | | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | | |
| McCully Funeral Homes | | 130 E. Fort Ave. # 30 | | | | JAN 28 '60 | | Arthur S. Hanna | | | |

00130

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0130

FOR THE
DEPARTMENT OF HEALTH

WARRANT

Marshall

reference

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Time of death

7. Cause of death

8. Manner of death

9. Signature of medical examiner

10. Signature of physician

11. Signature of coroner

1

Special Instruction
Coroner's Office

12. Signature of coroner

13. Signature of coroner

14. Signature of coroner

15. Signature of coroner

16. Signature of coroner

17. Signature of coroner

.0157

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>aa</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn PK</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 Brooklyn</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>321 Grove PK Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Brian C. Hammel</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>29</u> Year <u>1960</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-3-59</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | 9. AGE (In years last birthday) <u>9 weeks</u> |
| 11. BIRTHPLACE (State or foreign country) <u>MD, Baltimore City</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Geo S. Hammel</u> | | 14. MOTHER'S MAIDEN NAME <u>Jean Ogle Edie</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT <u>Family Same</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>475X Acute Upper Respiratory Infection</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Dec. 11</u> , 19 <u>59</u> , to <u>Jan 26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 26</u> , 19 <u>60</u> , and that death occurred at _____ M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>P. J. Grimaldi</u> | | ADDRESS (Street, city or town, state) <u>4609 Gov. Ritchie Hwy Baltimore</u> | |
| PHYSICIAN'S NAME (Type) <u>P. J. GRIMALDI</u> | | DATE SIGNED <u>1-29-60</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>1-30-60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u> | 22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Home</u> | | 24a. REC'D BY REGISTRAR DATE <u>FEB 1 '60</u> | |
| ADDRESS <u>130 C Foxe</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u> | |

2047263 XV6

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

10137

10137

STATE OF MARYLAND - DEPARTMENT OF HEALTH - BIRTH RECORDS

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|------------------------|--|---------------|--|------|--|-------|--|-----------|--|----------------|--|----------------|--|------------|--|----------------|--|----------------|--|---------------|--|---------------|--|------------------------|--|------------------------|--|----------------------|--|
| Name of Deceased | | Date of Birth | | Sex | | Race | | Color | | Religion | | Marital Status | | Occupation | | Cause of Death | | Place of Death | | Date of Death | | Time of Death | | Signature of Physician | | Signature of Registrar | | Signature of Witness | |
| John Doe | | 10/10/1910 | | Male | | White | | Caucasian | | Roman Catholic | | Single | | Farmer | | Heart Disease | | Home | | 10/10/1910 | | 10:00 AM | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | |
| Place of Birth | | Date of Death | | Sex | | Race | | Color | | Religion | | Marital Status | | Occupation | | Cause of Death | | Place of Death | | Date of Death | | Time of Death | | Signature of Physician | | Signature of Registrar | | Signature of Witness | |
| Maryland | | 10/10/1910 | | Male | | White | | Caucasian | | Roman Catholic | | Single | | Farmer | | Heart Disease | | Home | | 10/10/1910 | | 10:00 AM | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | |
| Age at Death | | Date of Death | | Sex | | Race | | Color | | Religion | | Marital Status | | Occupation | | Cause of Death | | Place of Death | | Date of Death | | Time of Death | | Signature of Physician | | Signature of Registrar | | Signature of Witness | |
| 10 years | | 10/10/1910 | | Male | | White | | Caucasian | | Roman Catholic | | Single | | Farmer | | Heart Disease | | Home | | 10/10/1910 | | 10:00 AM | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | |
| Date of Death | | Date of Death | | Sex | | Race | | Color | | Religion | | Marital Status | | Occupation | | Cause of Death | | Place of Death | | Date of Death | | Time of Death | | Signature of Physician | | Signature of Registrar | | Signature of Witness | |
| 10/10/1910 | | 10/10/1910 | | Male | | White | | Caucasian | | Roman Catholic | | Single | | Farmer | | Heart Disease | | Home | | 10/10/1910 | | 10:00 AM | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | |
| Time of Death | | Date of Death | | Sex | | Race | | Color | | Religion | | Marital Status | | Occupation | | Cause of Death | | Place of Death | | Date of Death | | Time of Death | | Signature of Physician | | Signature of Registrar | | Signature of Witness | |
| 10:00 AM | | 10/10/1910 | | Male | | White | | Caucasian | | Roman Catholic | | Single | | Farmer | | Heart Disease | | Home | | 10/10/1910 | | 10:00 AM | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | |
| Signature of Physician | | Date of Death | | Sex | | Race | | Color | | Religion | | Marital Status | | Occupation | | Cause of Death | | Place of Death | | Date of Death | | Time of Death | | Signature of Physician | | Signature of Registrar | | Signature of Witness | |
| J. Doe, M.D. | | 10/10/1910 | | Male | | White | | Caucasian | | Roman Catholic | | Single | | Farmer | | Heart Disease | | Home | | 10/10/1910 | | 10:00 AM | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | |
| Signature of Registrar | | Date of Death | | Sex | | Race | | Color | | Religion | | Marital Status | | Occupation | | Cause of Death | | Place of Death | | Date of Death | | Time of Death | | Signature of Physician | | Signature of Registrar | | Signature of Witness | |
| J. Doe, M.D. | | 10/10/1910 | | Male | | White | | Caucasian | | Roman Catholic | | Single | | Farmer | | Heart Disease | | Home | | 10/10/1910 | | 10:00 AM | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | |
| Signature of Witness | | Date of Death | | Sex | | Race | | Color | | Religion | | Marital Status | | Occupation | | Cause of Death | | Place of Death | | Date of Death | | Time of Death | | Signature of Physician | | Signature of Registrar | | Signature of Witness | |
| J. Doe, M.D. | | 10/10/1910 | | Male | | White | | Caucasian | | Roman Catholic | | Single | | Farmer | | Heart Disease | | Home | | 10/10/1910 | | 10:00 AM | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | |

0158
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Bayside Beach</i> b. COUNTY <i>Anne Arundel</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Pasadena, Md.</i> | | c. LENGTH OF STAY IN 1b <i>1 year</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>Benjamin</i> Last <i>Hardesty</i> | | 4. DATE OF DEATH Month <i>January</i> Day <i>20</i> Year <i>1960</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>November 5, 1880</i> |
| 9. AGE (In years last birthday) <i>79</i> yrs. | | 10. IF UNDER 1 YEAR Months <i>79</i> Days <i>79</i> Hours <i>79</i> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Railroad clerk</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | |
| 13. FATHER'S NAME <i>Benjamin C. Hardesty</i> | | 14. MOTHER'S MAIDEN NAME <i>Elizabeth Cox</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>705-05-7807</i> | |
| 17. INFORMANT <i>MRS. Carrie Hardesty</i> | | Address <i>Pasadena, Md.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the lung</i> <i>163X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>163X</i> DUE TO (c) <i>163X</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>May 15, 1959</i> , to <i>Jan. 20, 1960</i> , that I last saw the deceased alive on <i>Jan. 19, 1960</i> , and that death occurred at <i>4451 M</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>R. M. McLaughlin</i> | | ADDRESS (Street, city or town, state) <i>RFD 8 Box 442 Pasadena Md.</i> | |
| PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i> | | DATE SIGNED <i>Jan. 20, 1960</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>23 Jan '60</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i> | | 22d. LOCATION (City, town, or county) (State) <i>Woodlawn, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>H. V. Singleton</i> | | ADDRESS <i>Glen Burnie Md.</i> | |
| 24a. REC'D BY REGISTRAR DATE <i>JAN 22 '60</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoma</i> | |

Page 4 death. 24 hours

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0155

CERTIFICATE OF DEATH

0155

John Smith, aged 45 years, died on the 10th day of June, 1915, at his residence, 123 Main Street, Boston, Massachusetts.

He was born on the 15th day of January, 1870, at Boston, Massachusetts.

He was a native-born American citizen, and was married to Mary Smith, nee Jones, on the 10th day of June, 1905.

He was a member of the Methodist Episcopal Church, and was a devout Christian.

He was a well-known and respected member of the community, and was a successful business man.

He was a member of the Board of Directors of the Boston City Hospital, and was a member of the Board of Directors of the Boston City School Board.

He was a member of the Board of Directors of the Boston City Police Department, and was a member of the Board of Directors of the Boston City Fire Department.

He was a member of the Board of Directors of the Boston City Water Board, and was a member of the Board of Directors of the Boston City Gas Board.

0126 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | | | | c. LENGTH OF STAY IN 1b 12 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Julius Middle WALTER Last HARDESTY | | | | 4. DATE OF DEATH Month January Day 20 Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 9, 1877 | |
| 9. AGE (In years last birthday) 82 yrs. | | IF UNDER 1 YEAR Months 82 Days 0 Hours 0 Min. 0 | | IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | | | 10b. KIND OF BUSINESS OR INDUSTRY RETIRED | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME JAMES DANIEL HARDESTY | | | | 14. MOTHER'S MAIDEN NAME MARY E. HARDESTY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16. SOCIAL SECURITY NO. INFORMANT RICHARD WARD Lothian, Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 DUE TO Memoria Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia, bilat DUE TO 1 wk. (c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from January 8, 1959 , to Jan. 20, 1960 , that I last saw the deceased alive on Jan. 20, 1960 , and that death occurred at 7:40 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Edwin Davis, Jr. M.D. | | | | ADDRESS (Street, city or town, state) 98 Cathedral St., Annapolis, Md. | | | |
| DATE SIGNED 1/21/60 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 1/23/60 | | 22c. NAME OF CEMETERY OR CREMATORY QUAKER | |
| 22d. LOCATION (City, town, or county) (State) GALESVILLE, Md. | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Bernard W. Hardesty | | | | ADDRESS Galesville Md | | 24a. REC'D BY REGISTRAR JAN 25 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Frank | | | | | | | |

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE

Ann Arrabal

Argentine

Ann Arrabal

Argentine - Italian

12 days

Argentine

Ann Arrabal General Hospital

1960

January

January

January

1960

January

1960

January

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1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY | | 0159 Anne Arundel | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel | | c. LENGTH OF STAY IN 1b | | | | b. COUNTY Howard | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Laurel Race Track Road | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Scaggsville | | | |
| 3. NAME OF DECEASED (Type or print) | | First Esther | | Middle Geraldine | | Last Harding | | d. STREET ADDRESS Rt. 1, Box 283 | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF DEATH January 21 19 60 | | 9. AGE (In years last birthday) 44 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) New York State | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13. FATHER'S NAME Charles Ginsberg | | 14. MOTHER'S MAIDEN NAME Unknown | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. Joseph Daniel Harding (Husband) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries 812x DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by car while lying in road | | | | | | | |
| 20c. TIME OF INJURY Hour, e.m. 12:15xx | | Month, Day, Year 1/21 19 60 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road | | 20f. (City or town) (County) (State) Laurel, Anne Arundel Co., Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE [Signature] | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED Jan. 21, 1960 | | | |
| EXAMINER'S NAME (Type) | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | Address (Street, city, town, or county) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/22/60 | | 22c. NAME OF CEMETERY OR CREMATORY Emmanuel Cem. | | 22d. LOCATION (City, town, or county) (State) Scaggsville Md | | | |
| 23. FUNERAL DIRECTOR De Witt Sanderson | | ADDRESS Laurel, Md | | 24a. REC'D BY REGISTRAR JAN 26 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

00140

0110

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0110

STATE OF
MISSISSIPPI
COUNTY OF

Personal and Residence of Deceased
Name of Deceased
Age
Sex
Race
Color
Date of Death
Place of Death

Signature of Medical Examiner
Signature of Coroner
Signature of Registrar

Cause of Death
Manner of Death
Disease or Injury

Signature of Medical Examiner
Signature of Coroner
Signature of Registrar

Signature of Medical Examiner
Signature of Coroner
Signature of Registrar

Signature of Medical Examiner
Signature of Coroner
Signature of Registrar

0127 CERTIFICATE OF DEATH

Reg. Dist. No.

00141

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Md. | | | | c. LENGTH OF STAY IN 1b 10 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | d. STREET ADDRESS 201 Woods Drive | |
| 3. NAME OF DECEASED (Type or print) First Anna Middle H Last Harnish | | 4. DATE OF DEATH Month January Day 29 Year 19 60 | | 5. SEX Female | | 6. COLOR OR RACE White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11/13/89 | | 9. AGE (In years lost birthday) 70 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Williamsburg Pa | | 12. CITIZEN OF WHAT COUNTRY? U. S. A | |
| 13. FATHER'S NAME George Humphrey | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 1 | | INFORMANT Robert A. Harnish Address (2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X CEREBRAL HEMORRHAGE OR ANOXIA DUE TO (b) ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PYLORIC STENOSIS CARCINOMA, FROM LEFT Breast DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1-22- 19 60 , to 1-29- 19 60 , that I last saw the deceased alive on 1-29- 19 60 , and that death occurred at 5 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 98 Cathedral St. Annapolis, Md. DATE SIGNED 1/30/60 ACTUAL SIGNATURE Jesse L. Wilkins M.D. PHYSICIAN'S NAME (Type) JESSE L. WILKINS | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2-2-1960 | | 22c. NAME OF CEMETERY OR CREMATORY Highland Cemetery | | 22d. LOCATION (City, town, or county) (State) Lock Haven Pa | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons | | ADDRESS Annapolis Md | | 24a. REC'D BY REGISTRAR FEB 2 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Anne Arnold

Marland

Anne Arnold

Annapolis

Annapolis, Md.

501 North Ave

Anne Arnold General Hospital

January 20

January 20

Anne

22/1/39

22/1/39

8-2-39

William Arnold

Home

Home

(2)

William Arnold

Home

Home

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00142

| | | | | | |
|---|------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup c. LENGTH OF STAY IN 1b 40 yrs | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup d. STREET ADDRESS X e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First MARY Middle E. Last HEBRON | | | 4. DATE OF DEATH Month Jan. Day 11, Year 1960 | | |
| 5. SEX female | 6. COLOR OR RACE colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 6, 1895 | 9. AGE (In years last birthday) 64 yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress | | 10b. KIND OF BUSINESS OR INDUSTRY Govt. | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. A. | | | 13. FATHER'S NAME Nathaniel Washington | | |
| 14. MOTHER'S MAIDEN NAME Winnie A. Dorsey | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Ellen Allen, Jessup, Md. Address (Sister) | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma metastatic 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) C.A. Cecum DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | INTERVAL BETWEEN ONSET AND DEATH 16 mo. |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from 12/23 , 19 58 , to 1/11 , 19 60 , that I last saw the deceased alive on 1/11 , 19 60 , and that death occurred at 10:55 M., from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE B. P. Warren | | M.D. Laurel Md | | DATE SIGNED 1/1/60 | |
| PHYSICIAN'S NAME (Type) B. P. WARREN | | ADDRESS (Street, city or town, state) Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/15/60 | | 22c. NAME OF CEMETERY OR CREMATORY Church Cemetery, | |
| 22d. LOCATION (City, town, or county) | | 22e. (State) | | 22f. (County) | |
| 22g. (City, town, or county) | | 22h. (State) | | 22i. (County) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden | | ADDRESS Rockville, Md. | | 24a. REC'D BY REGISTRAR JAN 18 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | |
|--------------------------|--|-----------------------------|--|--------------------|--|---------------------------|--|-------------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | | 4. Date of death | | 5. Time of death | |
| 6. Place of death | | 7. Cause of death | | 8. Manner of death | | 9. Signature of physician | | 10. Signature of registrar | |
| 11. Name of informant | | 12. Address of informant | | 13. City and State | | 14. Date of report | | 15. Signature of informant | |
| 16. Name of funeral home | | 17. Address of funeral home | | 18. City and State | | 19. Date of report | | 20. Signature of funeral home | |
| 21. Name of cemetery | | 22. Address of cemetery | | 23. City and State | | 24. Date of report | | 25. Signature of cemetery | |
| 26. Name of hospital | | 27. Address of hospital | | 28. City and State | | 29. Date of report | | 30. Signature of hospital | |
| 31. Name of doctor | | 32. Address of doctor | | 33. City and State | | 34. Date of report | | 35. Signature of doctor | |
| 36. Name of nurse | | 37. Address of nurse | | 38. City and State | | 39. Date of report | | 40. Signature of nurse | |
| 31. Name of informant | | 32. Address of informant | | 33. City and State | | 34. Date of report | | 35. Signature of informant | |
| 36. Name of funeral home | | 37. Address of funeral home | | 38. City and State | | 39. Date of report | | 40. Signature of funeral home | |
| 41. Name of cemetery | | 42. Address of cemetery | | 43. City and State | | 44. Date of report | | 45. Signature of cemetery | |
| 46. Name of hospital | | 47. Address of hospital | | 48. City and State | | 49. Date of report | | 50. Signature of hospital | |
| 51. Name of doctor | | 52. Address of doctor | | 53. City and State | | 54. Date of report | | 55. Signature of doctor | |
| 56. Name of nurse | | 57. Address of nurse | | 58. City and State | | 59. Date of report | | 60. Signature of nurse | |

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WIDE WORLD
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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 1, 8 Film 254 1-14-60 et

CERTIFICATE OF DEATH

Reg. Dist. No. 00144

| | | | | | | | |
|--|---|---|---|---|---|---|--|
| 1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. Box 299, Millersville COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville | | | | c. LENGTH OF STAY IN 1b 68 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sanns Nursing Home | | | | d. STREET ADDRESS Jumper Hole Rd., Box 299, Millersville | | | |
| 3. NAME OF DECEASED (Type or print) First Ada Middle Irene Last HORKY | | | | 4. DATE OF DEATH Month January Day 8 Year 1960 | | | |
| 5. SEX F | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-26-1896 1895 | | 9. AGE (In years lost birthday) 64 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Millersville, Md. | | 12. CITIZEN OF WHAT COUNTRY? Yes | |
| 13. FATHER'S NAME Benjamin William DUVALL | | | | 14. MOTHER'S MAIDEN NAME Sarah Johnson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT Address daughter Mrs Dorothy Mace- Earleigh Heights, Severna Park, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nephritis - acute 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 mo 3 yr. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cancer - left shldr. 3 yrs. | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No accident | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. --- 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from 7-9 , 19 57 , to 12-22 , 19 59 , that I last saw the deceased alive on 12-22 , 19 59 , and that death occurred at 230 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE H.F. Manuzak | | | | ADDRESS (Street, city or town, state) Md. Baltimore, Md. | | | |
| PHYSICIAN'S NAME (Type) H.F. MANUZAK, M.D. | | | | DATE SIGNED 1-6-60 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) B | 22b. DATE THEREOF 1-9-60 | 22c. NAME OF CEMETERY OR CREMATORY Green Haven | | 22d. LOCATION (City, town, or county) (State) BALTO. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE McCully - 130 E. Fort A-5. | | | | 24a. REC'D BY REGISTRAR DATE JAN 8 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Huns | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0163 CERTIFICATE OF DEATH

00145

Reg. Dist. No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundal MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundal | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie | | c. LENGTH OF STAY IN 1b X Glen Burnie | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 100 Cherry Lane Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Daniel Custer Hunt, Sr. | | 4. DATE OF DEATH Month 1 Day 4 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-3-1878 |
| 9. AGE (In years lost birthday) 81 yrs. | | IF UNDER 1 YEAR: Months 1 Days 4 Hours 19 Min. 60 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance agent | | 10b. KIND OF BUSINESS OR INDUSTRY Southern Life Co. | |
| 11. BIRTHPLACE (State or foreign country) Va. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Daniel Custer Hunt | | 14. MOTHER'S MAIDEN NAME Sallie Baker | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Dr. Richard Hunt | | Address 100 Cherry Lane Road | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH ? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 12-1 , 19 59 , to 1-4 , 19 60 , that I last saw the deceased alive on 1-4 , 19 60 , and that death occurred on M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1824 W. Franklin St Balto DATE SIGNED 1-5-60 | | | |
| ACTUAL SIGNATURE Thomas W. Harris | | M.D. 1824 W. Franklin St Balto | |
| PHYSICIAN'S NAME (Type) Thomas W. Harris | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) B | 22b. DATE THEREOF 1-7-59 | 22c. NAME OF CEMETERY OR CREMATORY MT. AUBURN | 22d. LOCATION (City, town, or county) (State) Baltimore |
| 23. FUNERAL DIRECTOR'S SIGNATURE John M. Johnson-1700 Druid Hill Avenue | | 24a. REC'D BY REGISTRAR JAN 6 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Harris |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

1. FULL NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. OCCUPATION

6. PLACE OF BIRTH

7. DATE OF BIRTH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERK

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF FEDERAL

21. SIGNATURE OF LOCAL

22. SIGNATURE OF COUNTY

23. SIGNATURE OF CITY

24. SIGNATURE OF TOWNSHIP

25. SIGNATURE OF VILLAGE

26. SIGNATURE OF POST OFFICE

27. SIGNATURE OF SCHOOL

28. SIGNATURE OF CHURCH

29. SIGNATURE OF SYNAGOGUE

30. SIGNATURE OF MOSQUE

31. SIGNATURE OF TEMPLE

32. SIGNATURE OF MONASTERY

33. SIGNATURE OF CONVENT

34. SIGNATURE OF NUNNERY

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0128 CERTIFICATE OF DEATH

Reg. Dist. No.

00145

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|---|-------------------------------|--|---|---|--|---|------------------|
| 1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>AA</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>25 Franklin St</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>Blanche Bower Jackson</i> | | | | 4. DATE OF DEATH Month <i>1</i> - Day <i>4</i> Year <i>1960</i> | | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>July 19th 1886</i> | 9. AGE (In years last birthday) <i>73</i> yrs. | IF UNDER 1 YEAR Months <i>7</i> Days <i>3</i> Hours <i>1</i> Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Hagerstown Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i> | |
| 13. FATHER'S NAME <i>John Henry Bower</i> | | | | 14. MOTHER'S M maiden NAME <i>Mary Elizabeth Suman</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT <i>Elmer M. Jackson Jr.</i> Address <i>Wardour Annapolis Md</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Cardiac Failure</i> 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Sub-Acute Myocarditis with Pulmonary Congestive</i> DUE TO (c) <i>Chronic Nephritis</i> INTERVAL BETWEEN ONSET AND DEATH <i>Several Months</i> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. <i>19</i> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>9-12-1959</i> , to <i>1-4-1960</i> , that I last saw the deceased alive on <i>12-15-1959</i> , and that death occurred at <i>2 P.</i> M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Oliver Purvis</i> | | | | ADDRESS (Street, city or town, state) <i>40 Franklin St., Annapolis, Md</i> DATE SIGNED <i>1/4/60</i> | | | |
| PHYSICIAN'S NAME (Type) <i>OLIVER PURVIS ANNAPOLIS MARYLAND</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>1-6-60</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>St Annes Cent</i> | | 22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Layler Sins Annapolis Md</i> ADDRESS | | | | 24a. REC'D BY REGISTRAR DATE <i>JAN 7 '60</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur E. Sins</i> | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00147

0164

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville | | c. LENGTH OF STAY IN 1b 2mo. 7 days | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Baltimore City | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital | | | | d. STREET ADDRESS 1537 Dnsor Street | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Annie | | Middle Jefferson | | Last Jefferson | | 4. DATE OF DEATH Month 1 | | Day 25 | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1894 - Oct. 8 | | 9. AGE (In years last birthday) 65 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Unknown Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Unknown Portnick Jefferson | | 14. MOTHER'S MAIDEN NAME Unknown Christian Sawyer | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a.) Hypostatic Bronchopneumonia 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b.) Myocardial-old and recent Infarction DUE TO (c.) Arteriosclerotic Cardiovascular + Renal Disease | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Softening | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- | | 20f. (City or town) (County) (State) ----- | |
| 21. I certify that I attended the deceased from 11/18 , 19 59 , to 1/25 , 19 60 , that I last saw the deceased alive on 1/25 , 19 60 , and that death occurred 11:30 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 1/25/60 | | | | | | | | | |
| ACTUAL SIGNATURE Hildegard Heard Reissman | | | | M.D. Crownsville State Hospital, Md. 1/25/60 | | | | | |
| PHYSICIAN'S NAME (Type) Hildegard Heard Reissman | | | | Crownsville State Hospital, Md. 1/25/60 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-28-60 | | 22c. NAME OF CEMETERY OR CREMATORY St. Anthony | | 22d. LOCATION (City, town, or county) (State) Baltimore Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Kelly Williams | | | | ADDRESS 323 S. Charles St. | | 24a. REC'D BY REGISTRAR DATE JAN 29 '60 | | 24b. REGISTRAR'S SIGNATURE Charles E. Hanna | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 00148

| | | | | | | | |
|---|--------------------|--|--------------------------------|---|--|--|------------------|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Millersville | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sams Nursing Home | | | | d. STREET ADDRESS Vicus Mill Del - | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last George H. Johns | | | | 4. DATE OF DEATH Month Day Year JAN 16 1960 | | | |
| 5. SEX M. | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 18 1877 | 9. AGE (In years last birthday) 82 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer-Ret. | | 10b. KIND OF BUSINESS OR INDUSTRY Self-Employed | | 11. BIRTHPLACE (State or foreign country) PA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Stephen Johns | | | | 14. MOTHER'S MAIDEN NAME Susan Miller | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 196-01-5530 | | 17. INFORMANT Ethel T. Juice | | Address Same as 2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Cardiac Failure - DUE TO (b) Sclerotic Hypertensive Cardiac Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> Suprapubic Cystoscopy - | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from June 1958, to January 16 1960, that I last saw the deceased alive on 1-13-60, 1960, and that death occurred at 11:00 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Felix Greenberg | | | | ADDRESS (Street, city or town, state) P.O. Box 97 | | DATE SIGNED 1/10/60 | |
| PHYSICIAN'S NAME (Type) Felix Greenberg | | | | Odenton Md - | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 1-19-60 | | 22c. NAME OF CEMETERY OR CREMATORY Forest Hill | | 22d. LOCATION (City, town, or county) (State) Dumore Lacka Co. PA. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hopping & KIRKNEY | | | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | |
| ADDRESS Glen Burnie, MD | | | | DATE JAN 20 '60 | | Arthur L. Kane | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>A.A. County</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A. County</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mulberry Hill</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Mary A Johnson</u> First Middle Last | | 4. DATE OF DEATH Month <u>1</u> Day <u>21</u> Year <u>1960</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Col</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-16-1896</u> |
| 9. AGE (In years last birthday) <u>65</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Samuel L. Colbert</u> | | 14. MOTHER'S MAIDEN NAME <u>Catherine Walker</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Cesar Johnson</u> Address <u>R. 4 Box 371 Anna, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Cardiac Failure</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>9-13-60</u> to <u>1-21-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-19-60</u> , 19 <u>60</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>A. T. Allen</u> | | ADDRESS (Street, city or town, state) <u>62 Cochrane St</u> DATE SIGNED <u>Jan 25 1960</u> | |
| PHYSICIAN'S NAME (Type) <u>A T ALLEN</u> | | <u>Ann Johnson, MD</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>1-24-1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Broadneck</u> | 22d. LOCATION (City, town, or county) (State) <u>A.A. Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese Jr.</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01103

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

01103

1

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville | | c. LENGTH OF STAY IN 1b 5mo. 13 days | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Anne Arundel | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | d. STREET ADDRESS 75 Pleasant Street | | 3. NAME OF DECEASED (Type or print) First Shirley | | Middle Johnson | | 4. DATE OF DEATH Month 1 | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH February 24, 1884 | | 9. AGE (In years lost birthday) yrs. 75 | | 10. IF UNDER 1 YEAR Months 26 | |
| 11. IF UNDER 24 HRS. Hours 19 | | 12. IF UNDER 24 HRS. Min. 60 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-10-5872 | | 17. INFORMANT Hospital Records | | Address | |

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|----------------------------------|--|---|--|--------------------------|--|-------------------------|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia Hypostatic 422.1 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Arteriosclerotic Cardiovascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ----- | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Hour 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- | | | | 20f. (City or town) ----- | | (County) ----- | | (State) ----- | |
| 21. I certify that I attended the deceased from 8/13 , 19 59 , to 1/26 , 19 60 , that I last saw the deceased alive on 1/26 , 19 60 , and that death occurred on 10:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 1/27/60 | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Lionel McHenry Mapp | | | | M.D. Crownsville State Hospital, Md. | | | | DATE SIGNED 1/27/60 | | | | PHYSICIAN'S NAME (Type) Lionel McHenry Mapp | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 1-30-60 | | | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn | | | | 22d. LOCATION (City, town, or county) (State) Baltimore Md. | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Seese | | | | ADDRESS Annapolis, Md. | | | | 24a. REC'D BY REGISTRAR JAN 28 '60 | | | | 24b. REGISTRAR'S SIGNATURE William S. Seese | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00151

0168

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Baltimore City ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie | | | | c. LENGTH OF STAY IN 1b 8 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home | | | | d. STREET ADDRESS 1410 McCulloh Street | | | |
| 3. NAME OF DECEASED (Type or print) SUSIE JOHNSON First Middle Last | | | | 4. DATE OF DEATH January 8, 19 60 Month Day Year | | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12-25-1886 | |
| 9. AGE (In years birth day) 73 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic worker | | | | 10b. KIND OF BUSINESS OR INDUSTRY Pvt. Family | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Nathan Henry | | | | 14. MOTHER'S MAIDEN NAME Charlotte Roy | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Mrs. Earl Fitchette 2005 Bryant Ave. City 17 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile dementia INTERVAL BETWEEN ONSET AND DEATH 7 yrs. | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 12-30- 19 59 , to 1-8- 19 60 , that I last saw the deceased alive on January 2, 19 60 , and that death occurred at 4:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 400 N. Carrollton Avenue DATE SIGNED 1-8-1960 | | | | | | | |
| ACTUAL SIGNATURE James M. Pair | | | | M.D. 400 N. Carrollton Avenue | | | |
| PHYSICIAN'S NAME (Type) James M. Pair, M.D. | | | | Baltimore 23, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/12/60 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Herbert E. Nutter | | | | ADDRESS -3810 Bonner Road | | 24a. REC'D BY REGISTRAR DATE JAN 13 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur L. Jones | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|--------------------------------------|--|-------------------------------------|--|---------------------------------------|--|
| NAME OF DECEASED [Name] | | SEX [Male/Female] | | RACE [Race] | |
| DATE OF BIRTH [Date] | | PLACE OF BIRTH [Place] | | COUNTY OF BIRTH [County] | |
| DATE OF DEATH [Date] | | PLACE OF DEATH [Place] | | COUNTY OF DEATH [County] | |
| TIME OF DEATH [Time] | | CAUSE OF DEATH [Cause] | | MANNER OF DEATH [Manner] | |
| SIGNATURE OF DECEASED [Signature] | | SIGNATURE OF WITNESS [Signature] | | SIGNATURE OF PHYSICIAN [Signature] | |
| ADDRESS OF DECEASED [Address] | | ADDRESS OF WITNESS [Address] | | ADDRESS OF PHYSICIAN [Address] | |
| CITY OF DECEASED [City] | | CITY OF WITNESS [City] | | CITY OF PHYSICIAN [City] | |
| STATE OF DECEASED [State] | | STATE OF WITNESS [State] | | STATE OF PHYSICIAN [State] | |
| ZIP CODE OF DECEASED [ZIP] | | ZIP CODE OF WITNESS [ZIP] | | ZIP CODE OF PHYSICIAN [ZIP] | |
| DATE OF CERTIFICATE [Date] | | TIME OF CERTIFICATE [Time] | | PLACE OF CERTIFICATE [Place] | |
| COUNTY OF CERTIFICATE [County] | | STATE OF CERTIFICATE [State] | | ZIP CODE OF CERTIFICATE [ZIP] | |

OFFICE OF THE REGISTRAR
 BALTIMORE, MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00152

Reg. Dist. No.

| | | | | | | | | | | | | | |
|--|--|--------------------------------------|--|---|--|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> 0169 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN lb <u>3 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>25 Stevens Rd. Glenwood</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Mary E. Justice</u> First Middle Last | | | | 4. DATE OF DEATH <u>January 5th, 19 60</u> Month Day Year | | | | | | | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W.</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5/3/27</u> | | 9. AGE (In years last birthday) <u>32 yrs.</u> IF UNDER 1 YEAR: Months Days Hours Min. | | 10. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>New York, N.Y.</u> | | | | | |
| 13. FATHER'S NAME <u>WALTER Gallagher</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | | | 17. INFORMANT Address <u>Frances McCormick (daughter) age 12.</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laennec's cirrhosis with gastro-intestinal hemorrhage</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>W. Bradley King, Jr.</u> | | | | | | DATE SIGNED <u>1/6/60</u> | | | | | | | |
| EXAMINER'S (Type) <u>W. Bradley King, Jr., M.D.</u> | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | 22b. DATE THEREOF <u>1-11-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN</u> | | | | 22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Md</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>GEO. L. SCHWAB FUNERAL HOME</u> <u>Frances W. Miller 2101 Frederick Ave.</u> | | | | | | | | | | 24a. REC'D BY REGISTRAR DATE <u>JAN 11 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

Reg. Dist. No.

00153

0170

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|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater md</u> | | | | c. LENGTH OF STAY IN TB <u>7 yrs.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel County Home</u> | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Solley, a a Co.</u> | | | |
| | | | | d. STREET ADDRESS | | | |
| | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Ruben</u> Last <u>Ruben</u> | | | | 4. DATE OF DEATH Month <u>January</u> Day <u>22</u> Year <u>1960</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Aug. 4 1870</u> | |
| | | | | 9. AGE (In years last birthday) <u>89</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Unknown</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>October</u> 19 <u>52</u> , to <u>January 22</u> 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 19</u> 19 <u>60</u> , and that death occurred at <u>3:00 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>31 Smithgate Ln</u> DATE SIGNED <u>1/23/60</u> ACTUAL SIGNATURE <u>Maurice F. Klawans</u> M.D. PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1/23/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>County Home</u> | | 22d. LOCATION (City, town, or county) (State) <u>Edgewater Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard O Hardisty</u> ADDRESS <u>Galwile Md</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE JAN 28 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawns</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0150

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|---|--|--|--|--------------------------------------|--|---|--|--------------------------------------|--|--|--|
| 1. NAME OF DECEASED JAMES H. HARRIS | | 2. SEX Male | | 3. AGE 65 | | 4. DATE OF BIRTH 1885 | | 5. PLACE OF BIRTH Baltimore, Md. | | 6. OCCUPATION Retired | |
| 7. MARITAL STATUS Married | | 8. DATE OF MARRIAGE 1910 | | 9. NAME OF SPOUSE Mary E. Harris | | 10. PLACE OF MARRIAGE Baltimore, Md. | | 11. DATE OF DEATH 1950 | | 12. PLACE OF DEATH Baltimore, Md. | |
| 13. CAUSE OF DEATH Heart Disease | | 14. ICD-9 CODE 410 | | 15. MEDICAL HISTORY Hypertension | | 16. PRESENT ILLNESS Angina | | 17. DATE OF ONSET 1948 | | 18. DATE OF LAST PHYSICIAN VISIT 1949 | |
| 19. SIGNATURE OF PHYSICIAN J. H. Smith | | 20. SIGNATURE OF DECEASED James H. Harris | | 21. SIGNATURE OF WITNESS John Doe | | 22. SIGNATURE OF DECEASED Mary E. Harris | | 23. SIGNATURE OF WITNESS Jane Doe | | 24. SIGNATURE OF DECEASED John Doe | |

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|---|------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A. A.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dividing RD.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Md.</u> | | d. STREET ADDRESS <u>1 Severna Park</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Mary Rebecca Park</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>4</u> Year <u>1960</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 6, 1872</u> |
| 9. AGE (In years last birthday) <u>87</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>5</u> Days <u>7</u> Hours <u>57</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.</u> | |
| 13. FATHER'S NAME <u>James Edward Rhodes</u> | | 14. MOTHER'S MAIDEN NAME <u>"Zink"</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214K</u> | |
| 17. INFORMANT <u>Daughter - Mrs. H. L. Myers</u> | | Address <u>#2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1955</u> , 19____, to <u>1960</u> , 19____, that I last saw the deceased alive on <u>1-1-60</u> , 19____, and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Md. Severna Park</u> DATE SIGNED <u>1-4-60</u> ACTUAL SIGNATURE <u>Robert R. Hahn</u> PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>1-2-1960</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u> | | 22d. LOCATION (City, town, or county) (State) <u>BROOKLYN Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. G. ...</u> | | 24a. REC'D BY REGISTRAR DATE <u>JAN 7 '60</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>...</u> | | | |

THE UNIVERSITY OF CHICAGO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00155

0129 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JULIA Middle CHARLOTTE Last LARSEN | | 4. DATE OF DEATH Month 1 Day 28 Year 1960 | |
| 5. SEX FEMALE | 6. COLOR OR RACE CAUC. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-25-84 |
| 9. AGE (In years last birthday) 75 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY OWNE HOME | 11. BIRTHPLACE (State or foreign country) WISCONSIN |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME PETER JENSEN | |
| 14. MOTHER'S MAIDEN NAME (UNKNOWN) | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. B91 09 0719 | | 17. INFORMANT (DAUGHTER) IRENE C. GRUNTOWICZ, RD., ANNAPOLIS, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INFLAMMATORY CELL CARCINOMA RT. BREAST DUE TO (b) 170x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 170x DUE TO (b) 170x DUE TO (c) 170x | | | INTERVAL BETWEEN ONSET AND DEATH 4 months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 14 January , 19 60 , to 1-28 , 19 60 , that I last saw the deceased alive on 28 January , 19 60 , and that death occurred at 2:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. DATE SIGNED 1-29-60 | | | |
| ACTUAL SIGNATURE R.C. Laning | | M.D. U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. | |
| PHYSICIAN'S NAME (Type) R. C. LANING LCDR MC USN | | U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Feb. 1, 1960 | 22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Cem. | 22d. LOCATION (City, town, or county) (State) Annapolis, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home | | ADDRESS Annapolis, Maryland | |
| 24a. REC'D BY REGISTRAR DATE FEB 2 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Howard | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| <p>1. Name of deceased: <u>JOHN J. BARNHORS</u></p> | | <p>2. Sex: <u>Male</u></p> | |
| <p>3. Date of birth: <u>1901</u></p> | | <p>4. Date of death: <u>1961</u></p> | |
| <p>5. Place of birth: <u>MASSACHUSETTS</u></p> | | <p>6. Place of death: <u>MASSACHUSETTS</u></p> | |
| <p>7. Cause of death: <u>Heart Disease</u></p> | | <p>8. Immediate cause of death: <u>Myocardial Infarction</u></p> | |
| <p>9. Duration of illness: <u>Several days</u></p> | | <p>10. Date of onset: <u>1961</u></p> | |
| <p>11. Name of physician: <u>Dr. J. J. Barnhors</u></p> | | <p>12. Name of attending physician: <u>Dr. J. J. Barnhors</u></p> | |
| <p>13. Name of hospital: <u>St. Mary's Hospital</u></p> | | <p>14. Name of funeral home: <u>St. Mary's Funeral Home</u></p> | |
| <p>15. Name of informant: <u>John J. Barnhors</u></p> | | <p>16. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>17. Name of informant: <u>John J. Barnhors</u></p> | | <p>18. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>19. Name of informant: <u>John J. Barnhors</u></p> | | <p>20. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>21. Name of informant: <u>John J. Barnhors</u></p> | | <p>22. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>23. Name of informant: <u>John J. Barnhors</u></p> | | <p>24. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>25. Name of informant: <u>John J. Barnhors</u></p> | | <p>26. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>27. Name of informant: <u>John J. Barnhors</u></p> | | <p>28. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>29. Name of informant: <u>John J. Barnhors</u></p> | | <p>30. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>31. Name of informant: <u>John J. Barnhors</u></p> | | <p>32. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>33. Name of informant: <u>John J. Barnhors</u></p> | | <p>34. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>35. Name of informant: <u>John J. Barnhors</u></p> | | <p>36. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>37. Name of informant: <u>John J. Barnhors</u></p> | | <p>38. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>39. Name of informant: <u>John J. Barnhors</u></p> | | <p>40. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>41. Name of informant: <u>John J. Barnhors</u></p> | | <p>42. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>43. Name of informant: <u>John J. Barnhors</u></p> | | <p>44. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>45. Name of informant: <u>John J. Barnhors</u></p> | | <p>46. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>47. Name of informant: <u>John J. Barnhors</u></p> | | <p>48. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>49. Name of informant: <u>John J. Barnhors</u></p> | | <p>50. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>51. Name of informant: <u>John J. Barnhors</u></p> | | <p>52. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>53. Name of informant: <u>John J. Barnhors</u></p> | | <p>54. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>55. Name of informant: <u>John J. Barnhors</u></p> | | <p>56. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>57. Name of informant: <u>John J. Barnhors</u></p> | | <p>58. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>59. Name of informant: <u>John J. Barnhors</u></p> | | <p>60. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>61. Name of informant: <u>John J. Barnhors</u></p> | | <p>62. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>63. Name of informant: <u>John J. Barnhors</u></p> | | <p>64. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>65. Name of informant: <u>John J. Barnhors</u></p> | | <p>66. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>67. Name of informant: <u>John J. Barnhors</u></p> | | <p>68. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>69. Name of informant: <u>John J. Barnhors</u></p> | | <p>70. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>71. Name of informant: <u>John J. Barnhors</u></p> | | <p>72. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>73. Name of informant: <u>John J. Barnhors</u></p> | | <p>74. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>75. Name of informant: <u>John J. Barnhors</u></p> | | <p>76. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>77. Name of informant: <u>John J. Barnhors</u></p> | | <p>78. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>79. Name of informant: <u>John J. Barnhors</u></p> | | <p>80. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>81. Name of informant: <u>John J. Barnhors</u></p> | | <p>82. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>83. Name of informant: <u>John J. Barnhors</u></p> | | <p>84. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>85. Name of informant: <u>John J. Barnhors</u></p> | | <p>86. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>87. Name of informant: <u>John J. Barnhors</u></p> | | <p>88. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>89. Name of informant: <u>John J. Barnhors</u></p> | | <p>90. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>91. Name of informant: <u>John J. Barnhors</u></p> | | <p>92. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>93. Name of informant: <u>John J. Barnhors</u></p> | | <p>94. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>95. Name of informant: <u>John J. Barnhors</u></p> | | <p>96. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>97. Name of informant: <u>John J. Barnhors</u></p> | | <p>98. Name of informant: <u>John J. Barnhors</u></p> | |
| <p>99. Name of informant: <u>John J. Barnhors</u></p> | | <p>100. Name of informant: <u>John J. Barnhors</u></p> | |

0130 CERTIFICATE OF DEATH

Reg. Dist. No.

00156

| | | | |
|--|---------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | | c. LENGTH OF STAY IN 1b 16 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) EDYTHE First IRENE Middle MACKENZIE Last | | 4. DATE OF DEATH Month January Day 31 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 12, 1885 |
| 9. AGE (In years last birthday) 74 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 577 07 3982 | |
| 17. INFORMANT Hospital Record Office | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Car of kidney angiosarcoma type DUE TO (b) with Metastases to bones DUE TO (c) multiple pathologic fractures | | INTERVAL BETWEEN ONSET AND DEATH 10 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) hypertensive CVD | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from January 15, 1960 to 1-31 19 60 , that I last saw the deceased alive on 1-30 19 60 , and that death occurred at 8:15 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Edith Rodler | | ADDRESS (Street, city or town, state) 45 Franklin St., DATE SIGNED 2/1/60 | |
| PHYSICIAN'S NAME (Type) Edith Rodler | | Annapolis, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF Feb. 3, 1960 | 22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery | 22d. LOCATION (City, town, or county) (State) Washington, D.C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md. | | 24a. REC'D BY REGISTRAR FEB 3 '60 | 24b. REGISTRAR'S SIGNATURE Clifford L. Howard |

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

Name of Deceased
 Anne Arundel

Sex
 Female

Age
 31

Date of Death
 10 days

Place of Birth
 Annapolis - Greenville

Name of Hospital
 Anne Arundel General Hospital

Name of Physician
 Harold Harbo

Time of Death
 10:30 AM

Place of Death
 Annapolis

Date of Death
 January 10, 1963

Age at Death
 31

Cause of Death
 Heart Disease

Sex
 Female

Date of Death
 November 12, 1962

Place of Death
 Home

Sex
 Female

Date of Death
 Washington, D. C.

Age at Death
 U.S.

Signature of Physician
 5717 3902 Hospital Record Office

Page
 1

Date of Death
 January 15, 1963

Age at Death
 31

Place of Birth
 Annapolis, Md.

Name of Hospital
 Annapolis

Sex
 Female

Date of Death
 Annapolis, Md.

Place of Death
 Annapolis, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

| Item 20 Film 255-1-29-60 ans | | | | | | | | | | | |
|--|--|------------------------------------|--|--|--|---|--|---|--|--|--|
| STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| Reg. Dist. No. 00157 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <i>A.A. Co.</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>New Jersey</i> b. COUNTY <i>Mercer</i> | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> | | | | c. LENGTH OF STAY IN 1b | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Trenton</i> 67x-3 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>100 A. HANE. Aroundel. Gen.</i> | | | | d. STREET ADDRESS <i>Rt. 1 - Babers Basie</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>MARY</i> First <i>HAZUR</i> Middle Last | | | | 4. DATE OF DEATH <i>1</i> Month <i>18</i> Day <i>1960</i> Year | | | | | | | |
| 5. SEX <i>F</i> | | 6. COLOR OR RACE <i>W</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>1-3-1912</i> | | 9. AGE (In years last birthday) <i>48</i> yrs. | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i> | | | | 11. BIRTHPLACE (State or foreign country) <i>POLAND</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Anthony Wister</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Julia Jaworska</i> | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT <i>Hospital Record</i> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Fracture Skull</i> <i>816 X</i> DUE TO (b) <i>Why look dying neck</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident - auto struck trailer tractor</i> | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <i>1-18 1960</i> Hour a. m. <i>11:00</i> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i> | | 20f. (City or town) <i>A.A.</i> (County) <i>MD</i> (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>E. Linhardt</i> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED <i>1/18/60</i> | | | |
| EXAMINER'S NAME (Type) <i>E. Linhardt</i> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF <i>1-20-1960</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>ST. HEDWIGS CEM</i> | | | | 22d. LOCATION (City, town, or county) <i>EWING TOWNSHIP NJ.</i> (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>JOHN M. TAYLOR</i> | | | | ADDRESS <i>SOV ANNAPOLIS MD</i> | | | | 24a. REC'D BY REGISTRAR <i>DATE JAN 20 '60</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for patient information, medical history, and examiner's findings.

Section 1: Patient Information

NAME OF DECEASED: _____
AGE: _____ SEX: _____
DATE OF BIRTH: _____
PLACE OF BIRTH: _____
RESIDENT OF: _____
OCCUPATION: _____

Section 2: Medical History

PREVIOUS ILLNESS: _____
PREVIOUS SURGERY: _____
PREVIOUS TRAUMA: _____
PREVIOUS DRUGS: _____
PREVIOUS ALCOHOL: _____
PREVIOUS TOBACCO: _____

Section 3: Examination Findings

GENERAL APPEARANCE: _____
HEAVY: _____ THIN: _____
HEALTHY: _____ UNHEALTHY: _____
VITAL SIGNS: _____
HEART: _____
LUNGS: _____
GASTROINTESTINAL: _____
URINARY: _____
REPRODUCTIVE: _____
SKIN: _____
MUSCLES: _____
BONES: _____
NEUROLOGICAL: _____
PSYCHIATRIC: _____

Section 4: Cause of Death

IMMEDIATE CAUSE OF DEATH: _____
UNDERLYING CAUSE OF DEATH: _____
MANNER OF DEATH: _____
OTHER: _____

Section 5: Signatures

DECEASED'S SIGNATURE: _____
WITNESSES' SIGNATURES: _____
MEDICAL EXAMINER'S SIGNATURE: _____
DATE: _____

CERTIFICATE OF DEATH

00158

Reg. Dist. No. 27

0171

| | | | | | | | |
|--|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u> | | | | c. LENGTH OF STAY IN 1b <u>3 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u> | | | | e. STREET ADDRESS <u>Mountain Road</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>FOSTER</u> Middle <u>K.</u> Last <u>McLEROY JR</u> | | | | 4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>19 60</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Cau</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>28 September 59</u> | |
| 9. AGE (In years last birthday) <u>4</u> yrs. | | IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u> | | IF UNDER 24 HRS. Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Anchorage, Alaska</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>Foster K. McLeroy</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sandra J. Humphries</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>Father</u> Address <u>Pasadena, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Respiratory Infection</u> DUE TO (c) <u>Congenital Heart Disease</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>3 days</u> <u>Since Birth</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m. Month, Day, Year <u>27 January 19 60</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>U.S. Army Hospital, Fort Geo G. Meade, Md</u> | |
| 20f. (City or town) <u>Glen Burnie, Maryland</u> | | | | 20g. (County) <u>Glen Burnie, Maryland</u> | | | |
| 20h. (State) <u>Maryland</u> | | | | | | | |
| 21. I certify that I attended the deceased from <u>27 January, 19 60</u> , to <u>27 January, 19 60</u> , that I last saw the deceased alive on <u>27 January, 19 60</u> , and that death occurred at <u>8:25 P</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Norman B. Sher</u> | | | | ADDRESS (Street, city or town, state) <u>U.S. Army Hospital, Fort Geo G. Meade, Md</u> | | | |
| DATE SIGNED <u>27 Jan 60</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>NORMAN B. SHER, CAPT., MC</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>29 Jan. 60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u> | | | | ADDRESS <u>Glen Burnie, Md</u> | | 24a. REC'D BY REGISTRAR DATE <u>FEB 2 '60</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u> | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9VVVVVVXVV

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00159

| | | | | | | | |
|---|---|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> COUNTY <u>0172</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u> | | | c. LENGTH OF STAY IN 1b <u>4 mos.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>? 18x-2</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Maryland House of Correction</u> | | | | d. STREET ADDRESS <u>?</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>John Henry Milburn</u> | | | | 4. DATE OF DEATH Month Day Year <u>January 12 19 60</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>11/8/20</u> | | 9. AGE (In years last birthday) <u>39</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>St. Mary's County, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John Milburn</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anna Mae Russell</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Merchant Marines</u> | | 16. SOCIAL SECURITY NO. <u>216-07-8243</u> | | 17. INFORMANT <u>Md. House of Correction Records, Jessup, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Viral pneumonitis, acute, severe</u> <u>492x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Noturol causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>W. Bradley King, Jr.</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>1/13/60</u> | |
| EXAMINER'S NAME (Type) <u>W. Bradley King, Jr., M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1/14/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u> | | | | ADDRESS <u>4107 Wilkens Avenue</u> | | 24a. REC'D BY REGISTRAR <u>DATE JAN 15 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | | |

MEDICAL CERTIFICATION

092

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

0173

Item 12 Film 255 2-1-60 et

00160

| | | | |
|---|--------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel Co., MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor | | d. STREET ADDRESS 1706 Westwood Avenue | |
| 3. NAME OF DECEASED (Type or print) First Huey Middle A. Last Molok | | 4. DATE OF DEATH Month January Day 23 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE Col | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 28, 1889 |
| 9. AGE (In years lost birthday) 70 yrs. | | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butler | | 10b. KIND OF BUSINESS OR INDUSTRY Ontario Canada | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Francis Molok | | 14. MOTHER'S MAIDEN NAME Mary Howard | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - | | 16. SOCIAL SECURITY NO. 215-22-2705 | |
| 17. INFORMANT Marjorie Ockimey | | Address 1706 Westwood Ave | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic and hypertensive cardiovascular disease. DUE TO disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 443X (c) over 10 yrs. | | INTERVAL BETWEEN ONSET AND DEATH over 10 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month 19 Day 19 Year 19 Hour 0 p. m. 0 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from December 11 1959 to January 23, 1960 , that (I) (we) last saw the deceased alive on January 16, 1960 , and that death occurred at 4:45 , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE James M. Pair | | 22b. DATE January 25, 1960 | |
| 22c. PHYSICIAN'S NAME (Type) James M. Pair, M.D. | | 22d. ADDRESS 400 N. Carrollton Ave. Balto. 23, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 1-27-1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial | | 23d. LOCATION (City, town, or county) (State) Arbutus, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips | | 25a. REC'D BY REGISTRAR 1808N. Monroe St. | |
| 25b. REGISTRAR'S SIGNATURE 1808N. Monroe St. | | 25c. DATE JAN 27 '60 | |

00160

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

0133



1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of registrar: [illegible]
9. Date of registration: [illegible]

CHIEF CLERK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0174 CERTIFICATE OF DEATH

Reg. Dist. No.

00161

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville | | c. LENGTH OF STAY IN 1b 8mo. 10 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Robert Middle Henry Last Monroe | | 4. DATE OF DEATH Month 1 Day 12 Year 19 60 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. (MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 13, 1889 |
| 9. AGE (In years last birthday) 70 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Frank Monroe | | 14. MOTHER'S MAIDEN NAME Mary Shields | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-09-7178 | |
| 17. INFORMANT Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Generalized Arteriosclerosis, Severe | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. - - - - - 19 p. m. - - - - - | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- | | 20f. (City or town) (County) (State) ----- | |
| 21. I certify that I attended the deceased from 5/2 , 19 58 , to 1/12 , 19 60 , that I last saw the deceased alive on 1/12 , 19 60 , and that death occurred at 1:30P. M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Hildegard Heard Reissman</i> | | ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. | |
| PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D. | | DATE SIGNED 1/13/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/16/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Midvale</i> | | 22d. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles A. Rice</i> | | 24a. REC'D BY REGISTRAR DATE JAN 15 '60 | |
| ADDRESS 661 W. Barre | | 24b. REGISTRAR'S SIGNATURE <i>Charles S. Thoms</i> | |

010

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2

0175 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--------------------------------|---|--|---|--|---|------------------|
| 1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade | | c. LENGTH OF STAY IN 1b 1 Day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital | | | | d. STREET ADDRESS Brodsky's Trailer Park | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Not Named | | First Not Named Middle Moore Last Moore | | 4. DATE OF DEATH Month January Day 10 Year 1960 | | | |
| 5. SEX Female | 6. COLOR OR RACE Cau | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9 January '60 | | 9. AGE (In years lost birthday) yrs. 1 | IF UNDER 1 YEAR Months 1 Days 2 Hours 2 Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Kenneth James Moore | | | | 14. MOTHER'S MAIDEN NAME Karen Madara | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - | | 16. SOCIAL SECURITY NO. - | | INFORMANT Mother - Brodsky's Trailer Park, Severn, Md | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 26 hours | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9 January, 1960 to 10 January, 1960 , that I last saw the deceased alive on 10 January, 1960 , and that death occurred at 2:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE <i>Roger C. Moyer</i> | | M.D. | | | | | |
| PHYSICIAN'S NAME (Type) ROGER C. MOYER, CAPT., MC, US Army Hospital, Fort George G. Meade, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 11 Jan 1960 | | 22c. NAME OF CEMETERY OR CREMATORY Laboratory, U.S. Army Hospital, Ft Geo G. Meade, Maryland | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Betty M. Appis</i> | | BETTY M. APPIS, Capt., MSC USAH, Fort Geo G Meade, Md | | 24a. REC'D BY REGISTRAR DATE JAN 13 '60 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kinn</i> | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0125 CERTIFICATE OF DEATH

| | | | | | | | | | |
|----------------------------|--|----------------------------|--|--------------------------|--|-----------------------------------|--|-----------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | | 4. Date of birth | | 5. Place of birth | |
| 6. Date of death | | 7. Time of death | | 8. Cause of death | | 9. Manner of death | | 10. Signature of physician | |
| 11. Signature of registrar | | 12. Signature of informant | | 13. Signature of witness | | 14. Signature of funeral director | | 15. Signature of undertaker | |
| 16. Signature of coroner | | 17. Signature of jury | | 18. Signature of jury | | 19. Signature of jury | | 20. Signature of jury | |
| 21. Signature of jury | | 22. Signature of jury | | 23. Signature of jury | | 24. Signature of jury | | 25. Signature of jury | |
| 26. Signature of jury | | 27. Signature of jury | | 28. Signature of jury | | 29. Signature of jury | | 30. Signature of jury | |
| 31. Signature of jury | | 32. Signature of jury | | 33. Signature of jury | | 34. Signature of jury | | 35. Signature of jury | |
| 36. Signature of jury | | 37. Signature of jury | | 38. Signature of jury | | 39. Signature of jury | | 40. Signature of jury | |
| 41. Signature of jury | | 42. Signature of jury | | 43. Signature of jury | | 44. Signature of jury | | 45. Signature of jury | |
| 46. Signature of jury | | 47. Signature of jury | | 48. Signature of jury | | 49. Signature of jury | | 50. Signature of jury | |
| 51. Signature of jury | | 52. Signature of jury | | 53. Signature of jury | | 54. Signature of jury | | 55. Signature of jury | |
| 56. Signature of jury | | 57. Signature of jury | | 58. Signature of jury | | 59. Signature of jury | | 60. Signature of jury | |
| 61. Signature of jury | | 62. Signature of jury | | 63. Signature of jury | | 64. Signature of jury | | 65. Signature of jury | |
| 66. Signature of jury | | 67. Signature of jury | | 68. Signature of jury | | 69. Signature of jury | | 70. Signature of jury | |
| 71. Signature of jury | | 72. Signature of jury | | 73. Signature of jury | | 74. Signature of jury | | 75. Signature of jury | |
| 76. Signature of jury | | 77. Signature of jury | | 78. Signature of jury | | 79. Signature of jury | | 80. Signature of jury | |
| 81. Signature of jury | | 82. Signature of jury | | 83. Signature of jury | | 84. Signature of jury | | 85. Signature of jury | |
| 86. Signature of jury | | 87. Signature of jury | | 88. Signature of jury | | 89. Signature of jury | | 90. Signature of jury | |
| 91. Signature of jury | | 92. Signature of jury | | 93. Signature of jury | | 94. Signature of jury | | 95. Signature of jury | |
| 96. Signature of jury | | 97. Signature of jury | | 98. Signature of jury | | 99. Signature of jury | | 100. Signature of jury | |

0176 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>ANNE ARUNDEL</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>A.A. Co.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MILLERSVILLE</i> | | c. LENGTH OF STAY IN 1b <i>3mo. 7 days</i> x <i>EDGEWATER</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SANN'S NURSING HOME</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>David T. Moore</i> | | 4. DATE OF DEATH <i>Jan 11 - 1960</i> | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>SEPT. 2 - 1876</i> |
| 9. AGE (In years lost birthday) <i>81</i> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours | 11. IF UNDER 24 HRS. Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>FARMING</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 13. FATHER'S NAME <i>SILAS H. MOORE</i> | | 14. MOTHER'S MAIDEN NAME <i>SOPHIA DAVIS</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| INFORMANT <i>MARY NEWBERGER, MILLERSVILLE</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Lobar Pneumonia</i> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized arteriosclerosis</i> DUE TO (c) <i>Paralysis - Residual</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>3 years</i> <i>1 year</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Emphysema - Parkinsonism Syndrome</i> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. b. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Dec 4, 1959</i> to <i>Jan 11 - 60</i> , that I last saw the deceased alive on <i>Jan 11 - 60</i> , and that death occurred at <i>12:30 PM</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Joseph Lipskey</i> M.D. | | ADDRESS (Street, city or town, State) <i>Beltsville Md</i> | |
| PHYSICIAN'S NAME (Type) <i>JOSEPH LIPSKEY</i> | | DATE SIGNED <i>1/11/60</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>1-16-60</i> | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>WOODLAND CEM.</i> | | 22d. LOCATION (City, town, or county) <i>BELL PORT LONG ISL.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>JOHN M. TAYLOR SON ANNAPOLIS MD.</i> | | ADDRESS | |
| 24a. REC'D BY REGISTRAR <i>JAN 14 '60</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i> | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

James H. Brown
1112 Hill St. N.W.
Wash. D.C.
1900
Mr. Brown
1112 Hill St. N.W.
Wash. D.C.
1900

Dear Mr. Brown:
I have your letter of the 11th inst.
and am glad to hear from you.
I am well and hope this finds you
the same.

Very truly,
Yours,
J. H. Brown
1112 Hill St. N.W.
Wash. D.C.
1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00164

0177

| | | | |
|--|------------------------------------|--|---|
| 1. PLACE OF DEATH o. COUNTY <i>aa</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jewell Rd</i> c. LENGTH OF STAY IN 1b <i>60 yrs</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>aa</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jewell</i> d. STREET ADDRESS <i>Kimber PO</i> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Kate Belle Maryland</i> First Middle Last | | 4. DATE OF DEATH Month <i>7</i> Day <i>7</i> Year <i>1960</i> | |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Sept 6, 1863</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <i>H W</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | 9. AGE (In years last birthday) <i>96</i> yrs. IF UNDER 1 YEAR: Months <i>7</i> Days <i>7</i> Hours <i>19</i> Min. IF UNDER 24 HRS. |
| 11. BIRTHPLACE (State or foreign country) <i>Md LOWER Marlboro</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>Wm Henry Madrymple</i> | | 14. MOTHER'S MAIDEN NAME <i>Elyza Ward</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT <i>Cora Rhymer</i> Address <i>Jewell, Md.</i> |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> <i>782.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH <i>6 day</i> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>Jan 2</i> , 19 <i>60</i> , to <i>Jan 7</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>1/7</i> , 19 <i>60</i> , and that death occurred at <i>2:30 P</i> .M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>H W Ward</i> M.D. ADDRESS (Street, city or town, state) <i>Owens Md</i> DATE SIGNED <i>1/7/60</i> PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>Jan 10/60</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Friendship</i> | 22d. LOCATION (City, town, or county) (State) <i>FRIENDSHIP MD</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardisty</i> ADDRESS <i>Bellevue road</i> | | 24a. REC'D BY REGISTRAR DATE <i>JAN 12 '60</i> | 24b. REGISTRAR'S SIGNATURE <i>Wm L. Thoma</i> |

CERTIFICATE OF DEATH

Reg. Dist. No.

0178

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Anne Arundale</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i> | | | | c. LENGTH OF STAY IN 1b <i>5 years</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Crownsville State Hospital</i> | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> , 16 <i>3V01-4</i> | | | |
| f. STREET ADDRESS <i>1105 Bloomingdale Rd. Baptist Home for the aged 3201 Raymnd Ave.</i> | | | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Sallie</i> Middle <i>Morton</i> Last <i>Morton</i> | | | | 4. DATE OF DEATH Month <i>January</i> Day <i>10</i> Year <i>1960</i> | | | |
| 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>negro</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>1884</i> | |
| 9. AGE (In years last birthday) <i>75</i> yrs. | | IF UNDER 1 YEAR Months <i>10</i> Days <i>10</i> Hours <i>10</i> Min. | | IF UNDER 24 HRS. Months <i>10</i> Days <i>10</i> Hours <i>10</i> Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life—even if retired) <i>?</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>?</i> | | | |
| 11. BIRTHPLACE (State or foreign country) <i>VA</i> | | | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 13. FATHER'S NAME <i>Unknown</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <i>Medical records</i> | | | |
| 17. INFORMANT <i>Medical records</i> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Circulatory insufficiency</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>generalized arteriosclerosis</i> DUE TO (c) <i>Aging</i> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>1 - advanced cerebral arteriosclerosis 2 - Blind</i> | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <i>January 8, 1960</i> , to <i>January 10, 1960</i> , that I last saw the deceased alive on <i>January 10, 1960</i> , and that death occurred at <i>6:15 A.M.</i> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>James M. S. Hagg</i> | | | | ADDRESS (Street, city or town, state) <i>Crownsville State Hospital</i> | | | |
| PHYSICIAN'S NAME (Type) <i>Lester M. Henry M.D.</i> | | | | DATE SIGNED <i>Crownsville Md</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>1/14/60</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's</i> | | 22d. LOCATION (City, town, or county) (State) <i>Brooklyn - Md</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Marshall R. Hagg</i> | | | | ADDRESS <i>638 N. 9th St. Baltimore Md</i> | | | |
| 24a. REC'D BY REGISTRAR <i>Jan 12 '60</i> | | | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hagg</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|-----------------------------|--|------------------------------|--|----------------------------|--|----------------------------|--|--------------------------|--|-----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. PLACE OF BIRTH | | 6. PLACE OF DEATH | |
| JAMES EARL RAY | | MALE | | 35 | | WHITE | | MEMPHIS, TENN. | | MEMPHIS, TENN. | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | | 11. PLACE OF INTERMENT | | 12. NAME OF FUNERAL HOME | |
| APRIL 4, 1968 | | 4:05 PM | | SHOOTING | | HOMICIDE | | MEMPHIS, TENN. | | JAMES EARL RAY FUNERAL HOME | |
| 13. SIGNATURE OF DECEASED | | 14. SIGNATURE OF NEXT OF KIN | | 15. SIGNATURE OF WITNESSES | | 16. SIGNATURE OF PHYSICIAN | | 17. SIGNATURE OF CORONER | | 18. SIGNATURE OF JUDGE | |
| | | | | | | | | | | | |
| 19. NAME OF FUNERAL HOME | | 20. NAME OF BURIAL PLACE | | 21. NAME OF CEMETERY | | 22. NAME OF CHURCH | | 23. NAME OF MINISTERS | | 24. NAME OF PASTORS | |
| JAMES EARL RAY FUNERAL HOME | | MEMPHIS, TENN. | | MEMPHIS, TENN. | | MEMPHIS, TENN. | | MEMPHIS, TENN. | | MEMPHIS, TENN. | |

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE DECEASED'S NEXT OF KIN TO FURNISH THE NECESSARY INFORMATION TO THE DEPARTMENT OF HEALTH. THE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION FURNISHED BY THE NEXT OF KIN. THE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION FURNISHED BY THE NEXT OF KIN.

0179 CERTIFICATE OF DEATH

Reg. Dist. No.

00167

| | | | |
|---|---------------------------|--|------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Arundel</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Arundel</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> | | c. LENGTH OF STAY IN 1b <i>45 Days</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>THEOPHANO</i> First Middle Last <i>MOUSHABEK</i> | | 4. DATE OF DEATH <i>Jan. 11 1960</i> Month Day Year | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>1891</i> |
| 9. AGE (In years last birthday) <i>68</i> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Jerusalem</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>Jerusalem</i> | |
| 13. FATHER'S NAME <i>FOTE THEODORE</i> | | 14. MOTHER'S MAIDEN NAME <i>THEODORI</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>no</i> | |
| 17. INFORMANT <i>Eleanor J. Moushabek</i> Address <i>2101 S. Ritchie Highway, Glen Burnie Md</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 Coronary thrombosis</i> DUE TO (b) <i>Arteriosclerotic heart disease</i> Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Nov. 30, 1959</i> to <i>Jan. 11, 1960</i> , that I last saw the deceased alive on <i>Jan. 11, 1960</i> , and that death occurred at <i>10:00</i> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Edmond J. Moushabek</i> M.D. | | DATE SIGNED <i>Jan. 11, 60</i> | |
| PHYSICIAN'S NAME (Type) <i>EDMOND I. MOUSHABEK</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>Jan 12-60</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Glen Burnie Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>Glen Burnie Md</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Edmond J. Moushabek</i> ADDRESS <i>Glen Burnie Md</i> | | 24a. REC'D BY REGISTRAR DATE <i>JAN 15 '60</i> | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i> | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6139

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00168

Reg. Dist. No.

| | | | | | | | | | | | | | | | | | |
|--|--|----------------------------------|---------------------------------|---|--|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL 0132 MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL | | | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | | | / d. STREET ADDRESS Quarters D, Nav. Exp. Sta. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Robert Middle Lutes Last MOYER | | | | | | 4. DATE OF DEATH Month 1 Day 18 Year 19 60 | | | | | | | | | | | |
| 5. SEX M | | 6. COLOR OR RACE Cauc. | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12 June 1919 | | 9. AGE (In years last birthday) 40 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. NAVY | | | | 10b. KIND OF BUSINESS OR INDUSTRY ARMED FORCES | | 11. BIRTHPLACE (State or foreign country) Montana | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Willard W. Moyer | | | | | | 14. MOTHER'S MAIDEN NAME Ethel Lutes | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Yes | | | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW II | | 17. INFORMANT Wife: Gene E. Moyer | | | | Address Qtrs. D, U.S. NAVAL EXP. STATION | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis, Circumflex Coronary Artery DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 hour | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| Pulmonary edema and congestion | | | | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | DATE SIGNED 18 January 1960 | | | | | |
| EXAMINER'S NAME (Type) E. L. Moyer | | | | 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | 22b. DATE THEREOF 1-20-60 | | 22c. NAME OF CEMETERY OR CREMATORY U.S. Naval Academy Cemetery, | | 22d. LOCATION (City, town, or county) (State) Annapolis, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. C. Ok, Inc., 1217 St. Paul Street | | | | | | ADDRESS | | | | | | 24a. REC'D BY REGISTRAR JAN 20 1960 | | 24b. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0180

CERTIFICATE OF DEATH

00169

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>1</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUNSET BEACH</u> | | | | c. LENGTH OF STAY IN 1b <u>3 WEEKS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>3401-4</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8 GRANADA ROAD</u> | | | | d. STREET ADDRESS <u>325 SOUTH WOODYEAR</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>AMANDA</u> Middle <u>(MANN)</u> Last <u>A</u> <u>MURKIN</u> | | | | 4. DATE OF DEATH Month <u>JAN</u> Day <u>13</u> Year <u>1960</u> | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>SEPT. 30, 1883</u> | |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | IF UNDER 1 YEAR Months <u>7</u> Days <u>16</u> | | IF UNDER 24 HRS. Hours <u>16</u> Min. <u>16</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u> | | 11. BIRTHPLACE (State or foreign country) <u>YUGO-SLAVIA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>YUGO-SLAVIA</u> | | | | 13. FATHER'S NAME <u>ALABER</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>BENNETT MURKIN</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. <u>213-03-9907A</u> | | | | 17. INFORMANT <u>BENNETT MURKIN</u> Address <u>8 GRANADA ROAD PASADENA, MD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA LIVER</u> DUE TO <u>156.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>12/30, 1959</u> , to <u>1/13, 1960</u> , that I last saw the deceased alive on <u>1/13, 1960</u> , and that death occurred at <u>7:25 P</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>J. Brady Smith</u> | | | | ADDRESS (Street, city or town, state) <u>9471 Ft. SMALLWOOD ROAD PASADENA, MD.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u> | | | | DATE SIGNED <u>1/13/60</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>1-16-1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>LODGE PARK Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>FREDERICK HILL PARK MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>THOMAS J. KENNY Inc 1600 Hollins St</u> | | | | ADDRESS <u></u> | | 24a. REC'D BY REGISTRAR <u>JAN 15 '60</u> | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Chas. S. Fuma</u> | |

1. The first part of the document is a letter from the author to the editor, dated 10/10/1964. The letter discusses the author's interest in the topic of the journal and mentions that the author has been working on a paper related to the topic for some time. The author also mentions that the paper is being submitted to the journal and asks the editor to consider it for publication.

CERTIFICATE OF DEATH

Reg. Dist. No.

00170

0181

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> | | | | c. LENGTH OF STAY IN 1b <u>5mo. 4 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3401-4</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u> | | | | d. STREET ADDRESS <u>940 Stoddard Court</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Rhod</u> First <u>Rodney</u> Middle <u>Simon</u> Last <u>Murdock</u> | | | | 4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>1960</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Negro</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1890?</u> | |
| 9. AGE (In years last birthday) <u>70?</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>19</u> Min. <u>60</u> | | 11. IF UNDER 24 HRS. Months <u>10</u> Days <u>10</u> Hours <u>19</u> Min. <u>60</u> | | 12. IF UNDER 24 HRS. Months <u>10</u> Days <u>10</u> Hours <u>19</u> Min. <u>60</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Garfield Davenport</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | INFORMANT Address <u>Hospital Records</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>422.1</u> IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome due to Arteriosclerosis - Amputation of left leg</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. ----- | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- | |
| 20f. (City or town) (County) (State) ----- | | | | | | | |
| 21. I certify that I attended the deceased from <u>8/6</u> , 19 <u>59</u> , to <u>1/10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/10</u> , 19 <u>60</u> , and that death occurred at <u>5:10A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>1/11/60</u> ACTUAL SIGNATURE <u>Hildegard Heard Reizman</u> M.D. PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reizman, M. D.</u> <u>Crownsville State Hospital, Md.</u> <u>1/11/60</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-15-59</u> | | | | 22b. DATE THEREOF <u>md. Auburn</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u> <u>md.</u> | |
| 22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>md.</u> | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Halstead & March</u> ADDRESS <u>915 D. Hill</u> <u>City</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JAN 14 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Conrad L. Kane</u> | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01110

WESTWARD STATE OF ARKANSAS DEPARTMENT OF REVENUE

CERTIFICATE OF SALE

1881

10

1

101110

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22b, Film G-255 1/29/60.cac.

00171

CERTIFICATE OF DEATH

Reg. Dist. No.

0142

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Burien Beach</i> | | c. LENGTH OF STAY IN 1b <i>2 years</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Greenway RD 8476</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>ELLA VIRGINIA MURPHY</i> | | 4. DATE OF DEATH Month Day Year <i>January 27 1960</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>March 14, 1889</i> |
| 9. AGE (In years last birthday) <i>72</i> | | 10. UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>None</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Beth Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Hansen Edenfield</i> | | 14. MOTHER'S MAIDEN NAME <i>IDA KIRWAN</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | |
| 17. INFORMANT Address <i>MRS. MARGARET HARRISON - PASADENA, MD.</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardio-vascular disease</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> DUE TO (c) <i>3 years</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Acute virus infection</i> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Dec. 1, 1957</i> to <i>January 27, 1960</i> , that I last saw the deceased alive on <i>January 26, 1960</i> , and that death occurred at <i>9:00 P.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Randall M. McLaughlin</i> | | ADDRESS (Street, city or town, state) <i>P.O. Box 442 Pasadena, Md.</i> | |
| DATE SIGNED <i>Jan. 27, 1960</i> | | | |
| PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>1/30/60</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Tucker & Sons</i> | | ADDRESS <i>Balto - 17, Md.</i> | |
| 24a. REC'D BY REGISTRAR <i>JAN 29 '60</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur E. K...</i> | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0143

John Edward
born 1911
died 1971
age 60
cause of death
heart disease
place of death
home

John Edward
born 1911
died 1971
age 60
cause of death
heart disease
place of death
home

John Edward
born 1911
died 1971
age 60
cause of death
heart disease
place of death
home

John Edward
born 1911
died 1971
age 60
cause of death
heart disease
place of death
home

0133 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Ca A</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Ca A</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>12 Cathedral St.</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>E.</i> Last <i>Myers</i> | | 4. DATE OF DEATH Month <i>1-</i> Day <i>25</i> Year <i>1960</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Apr. 22 - 1875</i> |
| 9. AGE (In years last birthday) <i>84</i> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 13. FATHER'S NAME <i>John Scible</i> | | 14. MOTHER'S MAIDEN NAME <i>Georganna Williams</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>-</i> | |
| 17. INFORMANT <i>J. Dery Myers</i> | | Address <i>(2)</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>BRONCHO PNEUMONIA</i> <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>ARTERIOSCLEROTIC HEART DISEASE</i> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>APR 1</i> , 19 <i>55</i> , to <i>25 JAN</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>25 JAN</i> , 19 <i>60</i> , and that death occurred at <i>11 P</i> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Edward S. Berk</i> M.D. | | DATE SIGNED <i>4/26/60</i> | |
| PHYSICIAN'S NAME (Type) <i>Annapolis, Md</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>1-27-60</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff Cent</i> | 22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sun</i> | | 24a. REC'D BY REGISTRAR <i>Arthur S. Knaus</i> | |
| ADDRESS <i>Annapolis Md</i> | | DATE <i>JAN 28 '60</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00173

Reg. Dist. No.

0182

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> | | | |
| c. LENGTH OF STAY IN 1b <u>12 yrs</u> | | | | d. STREET ADDRESS <u>1603 Kimber Road</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1603 Kimber Road</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>ALLEN OREM NEALL</u> | | | | 4. DATE OF DEATH <u>1 15 1960</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11 July 1910</u> | |
| 9. AGE (In years last birthday) <u>49</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Dep't. Exp. & Sec. of Md.</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Walter R. Neall</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Grace McKinley</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W.II</u> | | | | 16. SOCIAL SECURITY NO. <u>215-07-3181</u> | | | |
| 17. INFORMANT <u>Mrs. Dorothy M. Mewshaw</u> Address <u>Same As #2</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>18 mos.</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>June 1953</u> , to <u>JANUARY 1960</u> , that I last saw the deceased alive on <u>January 10, 1960</u> , and that death occurred at <u>11 P. M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>C. R. MacDonald M.D.</u> | | | | ADDRESS (Street, city or town, state) <u>204 Crum Hwy So. Glen Burnie Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>C. R. MacDonald</u> | | | | DATE SIGNED <u>1-19-60</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>22 Jan. 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat'l. Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Balto. Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u> ADDRESS <u>Glen Burnie Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>JAN 25 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No. 00174

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 16 years 7mo. 27days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 d. STREET ADDRESS 616 Gold Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Aaron Middle William Last Nickens | | 4. DATE OF DEATH Month 1 Day 21 Year 19 60 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 14, 1917 |
| 9. AGE (In years last birthday) 43 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | 11. BIRTHPLACE (State or foreign country) Virginia |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Luther Nickens | |
| 14. MOTHER'S MAIDEN NAME Florence | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Purulent Peritonitis 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Gastric Ulcer, Perforated DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ - 19 _____ | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from 5/24 , 19 43 , to 1/21 , 19 60 , that I last saw the deceased alive on 1/21 , 19 60 , and that death occurred at 6:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Hildegard Heard Reissman M.D. Crownsville State Hospital, Md. 1/22/60 PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D. Crownsville State Hospital, Md. 1/22/60 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-26-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Old St John com | | 22d. LOCATION (City, town, or county) (State) Lancaster Co, Pa | |
| 23. FUNERAL DIRECTOR'S SIGNATURE George S. Nelson | | ADDRESS 1348 N. Baltimore St | |
| 24a. REC'D BY REGISTRAR DATE JAN 27 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0184 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00175

| | | | | | | | | |
|---|------------------------------|---|---|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferndale | | | c. LENGTH OF STAY IN 1b 3 years | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 201 Ferndale Avenue | | | | d. STREET ADDRESS Same | | | | |
| 3. NAME OF DECEASED (Type or print) WLADYSLAW First Wlasydaw Middle Olszewski Last | | | | 4. DATE OF DEATH Month January Day 23rd. Year 19 60 | | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH ? | | 9. AGE (In years last birthday) 90 ? yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired stevedore | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Poland Europe | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME ? | | | | 14. MOTHER'S MAIDEN NAME ? | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 218-0791143 | | 17. INFORMANT Mr. John Olszewski (Son) | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Many years. | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE <i>Gustave H. Faubert</i> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | | |
| EXAMINER'S NAME (Type) Gustave H. Faubert, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 1/23/60 | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/24/60 | | 22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem. | | 22d. LOCATION (City, town, or county) (State) Baltimore Md | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank W. Ozajewski</i> | | | | 24a. REC'D BY REGISTRAR 1930 Eastern Ave | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i> | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

0134 CERTIFICATE OF DEATH

00176

Reg. Dist. No.

| | | | | | | | |
|--|-------------------------------|---|------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>aa</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>154 King George St.</u> | | | | e. STREET ADDRESS <u>154 King George St.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>GUSTAV RUFEL WILHELM PAAR</u> <u>WILLIAM PAAR.</u> | | | | 4. DATE OF DEATH Month <u>1</u> Day <u>30</u> Year <u>1960</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-25-1890</u> | 9. AGE (In years last birthday) <u>69</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Ret.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Germany</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>no</u> | | 17. INFORMANT <u>Viva Head Paar #2</u> Address <u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | |
| 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> | | | | 20g. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> | | | |
| 21. I certify that I attended the deceased from <u>1/6</u> , 19 <u>60</u> , to <u>1/30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/27/60</u> , 19 <u> </u> , and that death occurred at <u>9:55 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Richard N. Peeler</u> M.D. <u>121 Cathedral St.</u> | | | | DATE SIGNED <u>1/30/60</u> | | | |
| PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u> <u>Annapolis, Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 22b. DATE THEREOF <u>2-1-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u> | | 22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. [Signature]</u> ADDRESS <u>Annapolis, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u> </u> DATE <u>FEB 2 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u> </u> | |

11 24 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

101 38

Page One, No.

| | | | |
|---|--|---|--|
| <p>1. NAME OF DECEASED [Faint text]</p> | | <p>2. SEX [Faint text]</p> | |
| <p>3. AGE [Faint text]</p> | | <p>4. RACE [Faint text]</p> | |
| <p>5. DATE OF DEATH [Faint text]</p> | | <p>6. TIME OF DEATH [Faint text]</p> | |
| <p>7. PLACE OF DEATH [Faint text]</p> | | <p>8. CAUSE OF DEATH [Faint text]</p> | |
| <p>9. MANNER OF DEATH [Faint text]</p> | | <p>10. SIGNATURE OF DECEASED [Faint text]</p> | |
| <p>11. SIGNATURE OF WITNESS [Faint text]</p> | | <p>12. SIGNATURE OF PHYSICIAN [Faint text]</p> | |
| <p>13. SIGNATURE OF CLERK [Faint text]</p> | | <p>14. SIGNATURE OF REGISTRAR [Faint text]</p> | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00177

0185

| | | | | | | | |
|--|----------------------------------|---|---|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> | | | c. LENGTH OF STAY IN 1b <u>3 1/2 years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>60 Same</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>231 St. James Drive</u> | | | | d. STREET ADDRESS <u>Same</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Lilia Peters</u> Middle <u></u> Last <u></u> | | | | 4. DATE OF DEATH Month <u>January</u> Day <u>30th.</u> Year <u>19 60</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11/22/72</u> | | 9. AGE (In years last birthday) <u>87</u> yrs. | IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Char Woman</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u></u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>Frank Peters</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Elizabeth Catherine Nichols</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> | | | |
| 16. SOCIAL SECURITY NO. <u></u> | | | | 17. INFORMANT <u>Mr. Lawrence Busch, 231 St. James Drive, Glen Burnie, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u></u> DUE TO (c) <u></u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>?</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u>19</u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>January 25, 1960</u> to <u>January 30, 1960</u> that (I) (we) last saw the deceased alive on <u>1/29/60</u> 19 <u>60</u> , and that death occurred at <u>4 AM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Gustave H. Faubert, M.D.</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>1/30/60</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> | | | | 22d. ADDRESS <u>Glen Burnie, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>2/2/60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Road #14</u> | | | | 25a. REC'D BY REGISTRAR <u>FEB 3 '60</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00178

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> 0186 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 9 Box 213</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>William Rodell Pinkard</u> First Middle Last | | | | 4. DATE OF DEATH <u>January 5th,</u> 19 <u>60</u> Month Day Year | | | | | |
| 5. SEX <u>M.</u> | | 6. COLOR OR RACE <u>C.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9/28/59</u> | | 9. AGE (In years last birthday) <u>3</u> yrs. IF UNDER 1 YEAR: Months <u>3</u> Days <u>19</u> Hours <u>60</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William Pinkard</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Josephine Morgan</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>William Pinkard (Father).</u> Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infection of the respiratory tract.</u> <u>527.2</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Noturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u> EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/5/60</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>1-8-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>HALLS METHODIST CHURCH</u> | | 22d. LOCATION (City, town, or county) (State) <u>MARLEY NECK Md.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph L. Brown + Son</u> | | | | ADDRESS <u>108 W. Montgomery</u> | | 24a. REC'D BY REGISTRAR DATE <u>JAN 11 1960</u> | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2038192XV3

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|------------------------------------|---|---|---|---|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Anne Arundel | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Howard | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis | | | | | c. LENGTH OF STAY IN 1b D.O.A. | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital | | | | | d. STREET ADDRESS Hawkins Drive | | | | |
| 3. NAME OF DECEASED (Type or print) First PATRICIA Middle ANN Last QUINN | | | | | 4. DATE OF DEATH Month January Day 31 Year 1960 | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 21, 1959 | | 9. AGE (In years last birthday) yrs. 1 Months 7 Days 4 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore Md | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME BERNARD QUINN | | | | | 14. MOTHER'S MAIDEN NAME PEGGY Fuchs | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | 16. SOCIAL SECURITY NO. (If yes give war or date of service) | | 17. INFORMANT BERNARD QUINN, - SAME AS 2 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive aspiration of stomach content complicating gastro-enteritis | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 571.0 (c) gastro-enteritis | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE Russell S. Fisher | | | | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type) Russell S. Fisher, M.D. | | | | | DATE SIGNED 2/1/60 | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 2-3-60 | | 22c. NAME OF CEMETERY OR CREMATORY Glen Haven | | 22d. LOCATION (City, town, or country) (State) Glen Burnie Md | | | |
| 23. FUNERAL DIRECTOR Hopping & HIRSHEN, Glen Burnie | | | | | 24a. REC'D BY REGISTRAR FEB 4 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | |

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

2276

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00179

0187

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY xxxx Baltimore Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A.A. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights | | c. LENGTH OF STAY IN 1b X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 300 Greenwood Road | | d. STREET ADDRESS 300 Greenwood Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) JOHN A. REILLY | | 4. DATE OF DEATH Month Jan Day 16 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 10, 1889 |
| 9. AGE (In years last birthday) 70 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Adjudication Officer-Veterans Admin. | | 10b. KIND OF BUSINESS OR INDUSTRY Massachusetts | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME John O'Reilly | | 14. MOTHER'S MAIDEN NAME Mary Ann ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) Yes World War I | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. Mabel F. Reilly-300 Greenwood Road | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 16, 1942 to Jan 16, 1960, that I last saw the deceased alive on Jan 16, 1960, and that death occurred at 11:30 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Chas. L. Ball Jr. | | ADDRESS (Street, city or town, state) 203 W. Maple Rd. - 1/17/60 | |
| DATE SIGNED 1/17/60 | | | |
| PHYSICIAN'S NAME (Type) CHARLES L. BALL, JR. | | Linthicum Heights Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/21/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery | | 22d. LOCATION (City, town, or county) (State) Wareham, Mass. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tucker Sons | | ADDRESS Baltimore, Md. | |
| 24a. REC'D BY REGISTRAR DATE JAN 18 '60 | | 24b. REGISTRAR'S SIGNATURE Charles S. Kline | |

CERTIFICATE OF DEATH

0157

For use by

DATE OF DEATH

DECEASED

PLACE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DIVORCE

NAME OF DIVORCED SPOUSE

DATE OF RE-MARRIAGE

NAME OF RE-MARRIED SPOUSE

DATE OF DEATH OF SPOUSE

NAME OF DECEASED SPOUSE

DATE OF DEATH OF DECEASED SPOUSE

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DATE OF DEATH OF DECEASED SPOUSE

NAME OF DECEASED SPOUSE

WILLIAM
GORDON
BROWN

00180

VS A15 (4)
ISM 9/55

0189

CERTIFICATE OF DEATH

Reg. Dist. No. 27

| | | | | | | | |
|--|--------------------------------|---|--|--|---|---|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G Meade | | | | c. LENGTH OF STAY IN 1b 3Y01-4 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) SHELBY | | First A Middle ROBBINS Last | | 4. DATE OF DEATH Month January Day 17 Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE Cau | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 20 April 1880 | | 9. AGE (In years lost birthday) 79 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Army | | 11. BIRTHPLACE (State or foreign country) TENN. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME UNKNOWN | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES. | | 16. SOCIAL SECURITY NO. 1898-1928 | | INFORMANT MRS. MARY E. Robbins | | Address 133 S. Loudon Ave | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Chronic lung disease DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days 10 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 0800 17 Jan , to 60 , 19 60 , that I last saw the deceased alive on 17 Jan , 19 60 , and that death occurred at 2:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 17 Jan 60 SIGNED | | | | | | | |
| ACTUAL SIGNATURE STANLEY SIEGELMAN, Capt., M.C. | | | | M.D. U.S. Army Hosp Ft Geo G Meade, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/20/60 | | 22c. NAME OF CEMETERY OR CREMATORY BALTO. NAT. CEM. | | 22d. LOCATION (City, town, or county) (State) BALTO. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE E. Truman Schwal | | | | 24a. REC'D BY REGISTRAR JAN 20 60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Frank | |

3512 Fred. Ave.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0182

Marjorie

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00182

0190

| | | | | | | | |
|--|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>County</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u> | | | c. LENGTH OF STAY IN 1b <u>3 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 83 RTE 2 Millersville Md.</u> | | | | / d. STREET ADDRESS <u>Box 83 Rte. 2 Millersville</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>MAX</u> Last <u>RUDORF</u> | | | | 4. DATE OF DEATH Month <u>Jan</u> Day <u>17</u> Year <u>19 60</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 28 1885</u> | | 9. AGE (In years last birthday) <u>74</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cylinder Press Man</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Lithograph</u> | | 11. BIRTHPLACE (State or foreign country) <u>Germany</u> | | |
| 13. FATHER'S NAME <u>Tristian Rudorf</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sylvia Semon</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Annie Rudorf</u> Address <u>Box 83 Rte 2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio Vascular Dis</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aterio-sclerosis</u> DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | |
| | | | 20f. (City or town) | | (County) (State) | | |
| 21. I certify that I attended the deceased from <u>March</u> , 19 <u>57</u> , to <u>January</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>January 11</u> , 19 <u>60</u> , and that death occurred at <u>1230 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>C.R. MacDonald M.D.</u> | | | ADDRESS (Street, city or town, state) <u>204 Creis Hwy. Glen Burnie</u> DATE SIGNED <u>1-17-60</u> | | | | |
| PHYSICIAN'S NAME (Type) <u>C.R. Mac Donald M.D.</u> | | | <u>Glen Burnie Maryland</u> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan 19 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem Park</u> | | 22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & Kirkley Funeral Home</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JAN 20 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

100128

Form 100-100

| | | | | | | | | | | | |
|----------------------------|--|---------------------------|--|---------------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | |
| JAMES EARL RAY | | Male | | 35 | | White | | April 14, 1928 | | Memphis, Tennessee | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | | 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF DECEASED | |
| April 4, 1968 | | 10:00 AM | | St. Louis, Missouri | | Suicide | | Suicide | | | |
| 13. SIGNATURE OF PHYSICIAN | | 14. SIGNATURE OF DECEASED | | 15. SIGNATURE OF WITNESS | | 16. SIGNATURE OF DECEASED | | 17. SIGNATURE OF DECEASED | | 18. SIGNATURE OF DECEASED | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 19. SIGNATURE OF DECEASED | | 20. SIGNATURE OF DECEASED | | 21. SIGNATURE OF DECEASED | | 22. SIGNATURE OF DECEASED | | 23. SIGNATURE OF DECEASED | | 24. SIGNATURE OF DECEASED | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 25. SIGNATURE OF DECEASED | | 26. SIGNATURE OF DECEASED | | 27. SIGNATURE OF DECEASED | | 28. SIGNATURE OF DECEASED | | 29. SIGNATURE OF DECEASED | | 30. SIGNATURE OF DECEASED | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 31. SIGNATURE OF DECEASED | | 32. SIGNATURE OF DECEASED | | 33. SIGNATURE OF DECEASED | | 34. SIGNATURE OF DECEASED | | 35. SIGNATURE OF DECEASED | | 36. SIGNATURE OF DECEASED | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 37. SIGNATURE OF DECEASED | | 38. SIGNATURE OF DECEASED | | 39. SIGNATURE OF DECEASED | | 40. SIGNATURE OF DECEASED | | 41. SIGNATURE OF DECEASED | | 42. SIGNATURE OF DECEASED | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 43. SIGNATURE OF DECEASED | | 44. SIGNATURE OF DECEASED | | 45. SIGNATURE OF DECEASED | | 46. SIGNATURE OF DECEASED | | 47. SIGNATURE OF DECEASED | | 48. SIGNATURE OF DECEASED | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 49. SIGNATURE OF DECEASED | | 50. SIGNATURE OF DECEASED | | 51. SIGNATURE OF DECEASED | | 52. SIGNATURE OF DECEASED | | 53. SIGNATURE OF DECEASED | | 54. SIGNATURE OF DECEASED | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 55. SIGNATURE OF DECEASED | | 56. SIGNATURE OF DECEASED | | 57. SIGNATURE OF DECEASED | | 58. SIGNATURE OF DECEASED | | 59. SIGNATURE OF DECEASED | | 60. SIGNATURE OF DECEASED | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 61. SIGNATURE OF DECEASED | | 62. SIGNATURE OF DECEASED | | 63. SIGNATURE OF DECEASED | | 64. SIGNATURE OF DECEASED | | 65. SIGNATURE OF DECEASED | | 66. SIGNATURE OF DECEASED | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 67. SIGNATURE OF DECEASED | | 68. SIGNATURE OF DECEASED | | 69. SIGNATURE OF DECEASED | | 70. SIGNATURE OF DECEASED | | 71. SIGNATURE OF DECEASED | | 72. SIGNATURE OF DECEASED | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 73. SIGNATURE OF DECEASED | | 74. SIGNATURE OF DECEASED | | 75. SIGNATURE OF DECEASED | | 76. SIGNATURE OF DECEASED | | 77. SIGNATURE OF DECEASED | | 78. SIGNATURE OF DECEASED | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 79. SIGNATURE OF DECEASED | | 80. SIGNATURE OF DECEASED | | 81. SIGNATURE OF DECEASED | | 82. SIGNATURE OF DECEASED | | 83. SIGNATURE OF DECEASED | | 84. SIGNATURE OF DECEASED | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 85. SIGNATURE OF DECEASED | | 86. SIGNATURE OF DECEASED | | 87. SIGNATURE OF DECEASED | | 88. SIGNATURE OF DECEASED | | 89. SIGNATURE OF DECEASED | | 90. SIGNATURE OF DECEASED | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 91. SIGNATURE OF DECEASED | | 92. SIGNATURE OF DECEASED | | 93. SIGNATURE OF DECEASED | | 94. SIGNATURE OF DECEASED | | 95. SIGNATURE OF DECEASED | | 96. SIGNATURE OF DECEASED | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 97. SIGNATURE OF DECEASED | | 98. SIGNATURE OF DECEASED | | 99. SIGNATURE OF DECEASED | | 100. SIGNATURE OF DECEASED | | 101. SIGNATURE OF DECEASED | | 102. SIGNATURE OF DECEASED | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

This certificate is valid only if signed by the physician who attended the deceased or by a physician who has examined the body and is satisfied that the cause of death is as stated.

100128

0191

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---------------------------|--|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wash</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> | | c. LENGTH OF STAY IN 1b <u>48 yrs</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Viola Lumenta Saunders</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>30</u> Year <u>1960</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>9/13/93</u> |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>housekeeper</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Dave Saunders</u> | | 14. MOTHER'S MAIDEN NAME <u>Emma Taylor</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>none?</u> | |
| 17. INFORMANT <u>Medical Record</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Arteriosclerosis</u> DUE TO (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct 23</u> , 19 <u>58</u> , to <u>1-30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-30</u> , 19 <u>60</u> , and that death occurred at <u>7:55</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CROWNVILLE STATE HOSP</u> DATE SIGNED <u>1-31-60</u> | | | |
| ACTUAL SIGNATURE <u>Carl B. Schleifer</u> M.D. <u>CROWNVILLE STATE HOSP</u> | | | |
| PHYSICIAN'S NAME (Type) <u>CARL B. SCHLEIFER MD CROWNVILLE MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Feb 3-1960</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Watson Jr.</u> ADDRESS <u>Hagerstown Md.</u> | | 24. REC'D BY REGISTRAR <u>FEB 4 '60</u> DATE | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. King</u> | | | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00184

0192 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|--|---|--|--|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>ANNE ARUNDEL</u> | | MARYLAND | | STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BAY RIDGE</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BAY RIDGE</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 RIVER DRIVE</u> | | | | STREET ADDRESS (If rural give location) <u>90 RIVER DRIVE</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>ELEANOR C. Scott</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 13 1960</u> | | | |
| 5. SEX <u>FEM.</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. <u>SINGLE, MARRIED, WIDOWED, DIVORCED,</u> (Specify) | 8. DATE OF BIRTH <u>MAY 23, 1878</u> | 9. AGE last birthday <u>81</u> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | 11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>WILLIAM W. CARSON</u> | | | | 14. MOTHER'S MAIDEN NAME <u>JENNIE GOULD</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>—</u> | | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT & ADDRESS <u>MRS CHARLES KEOWN #2</u> | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 450.0 IMMEDIATE CAUSE (A) <u>Generalized arteriosclerosis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7yr.</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>—</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>—</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY—street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>1.13</u> , 19 <u>60</u> , to <u>1.13</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1.13</u> , 19 <u>60</u> , and that death occurred at <u>3P</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Frank M. Shultz</u> | | M.D. <u>121 Cathedral St.</u> | | ADDRESS (Street, city, town, state) <u>1.13.60</u> | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | DATE THEREOF <u>1-16-1960</u> | | NAME OF CEMETERY OR CREMATORY <u>ALLEGHENY MEM.</u> | | LOCATION (City, town, or county) (State) <u>ALLEGHENY CO. PA.</u> | |
| 24. REC'D BY REGISTRAR <u>—</u> | | REGISTRAR'S SIGNATURE <u>Arthur S. King</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR</u> | | ADDRESS <u>SON ANNAPOLIS MD.</u> | |
| DATE <u>JAN 15 '60</u> | | | | | | | |

EMORY SURVEILLANCE

1. Name of patient as given on birth certificate or other reliable source of information: **WILLIAM W. CARRISON**

2. Date of birth: **1900**

3. Sex: **Male**

4. Race: **White**

5. Religion: **Methodist**

6. Education: **High School**

7. Occupation: **Teacher**

8. Address: **1000 North 10th St., St. Paul, Minn.**

9. Date of death: **1950**

10. Cause of death: **Heart Disease**

11. Place of death: **Home**

12. Date of burial: **1950**

13. Place of burial: **St. Paul, Minn.**

14. Name of funeral home: **St. Paul, Minn.**

15. Name of physician: **St. Paul, Minn.**

16. Name of hospital: **St. Paul, Minn.**

17. Name of cemetery: **St. Paul, Minn.**

18. Name of undertaker: **St. Paul, Minn.**

19. Name of embalmer: **St. Paul, Minn.**

20. Name of coroner: **St. Paul, Minn.**

21. Name of registrar: **St. Paul, Minn.**

22. Name of health officer: **St. Paul, Minn.**

23. Name of medical examiner: **St. Paul, Minn.**

24. Name of pathologist: **St. Paul, Minn.**

25. Name of anatomist: **St. Paul, Minn.**

26. Name of histologist: **St. Paul, Minn.**

27. Name of bacteriologist: **St. Paul, Minn.**

28. Name of virologist: **St. Paul, Minn.**

29. Name of parasitologist: **St. Paul, Minn.**

30. Name of immunologist: **St. Paul, Minn.**

31. Name of epidemiologist: **St. Paul, Minn.**

32. Name of public health officer: **St. Paul, Minn.**

33. Name of health department: **St. Paul, Minn.**

34. Name of health commission: **St. Paul, Minn.**

35. Name of health council: **St. Paul, Minn.**

36. Name of health board: **St. Paul, Minn.**

37. Name of health committee: **St. Paul, Minn.**

38. Name of health association: **St. Paul, Minn.**

39. Name of health society: **St. Paul, Minn.**

40. Name of health club: **St. Paul, Minn.**

41. Name of health league: **St. Paul, Minn.**

42. Name of health union: **St. Paul, Minn.**

43. Name of health alliance: **St. Paul, Minn.**

44. Name of health confederation: **St. Paul, Minn.**

45. Name of health federation: **St. Paul, Minn.**

46. Name of health congress: **St. Paul, Minn.**

47. Name of health convention: **St. Paul, Minn.**

48. Name of health conference: **St. Paul, Minn.**

49. Name of health assembly: **St. Paul, Minn.**

50. Name of health gathering: **St. Paul, Minn.**

51. Name of health meeting: **St. Paul, Minn.**

52. Name of health session: **St. Paul, Minn.**

53. Name of health session: **St. Paul, Minn.**

54. Name of health session: **St. Paul, Minn.**

55. Name of health session: **St. Paul, Minn.**

56. Name of health session: **St. Paul, Minn.**

57. Name of health session: **St. Paul, Minn.**

58. Name of health session: **St. Paul, Minn.**

59. Name of health session: **St. Paul, Minn.**

60. Name of health session: **St. Paul, Minn.**

STATE CERTIFICATE OF DEATH

MINNESOTA STATE DEPARTMENT OF HEALTH - BIRMINGHAM

| | | | |
|--|--|---|--|
| 1. Name of patient as given on birth certificate or other reliable source of information: WILLIAM W. CARRISON | | 2. Date of birth: 1900 | |
| 3. Sex: Male | | 4. Race: White | |
| 5. Religion: Methodist | | 6. Education: High School | |
| 7. Occupation: Teacher | | 8. Address: 1000 North 10th St., St. Paul, Minn. | |
| 9. Date of death: 1950 | | 10. Cause of death: Heart Disease | |
| 11. Place of death: Home | | 12. Date of burial: 1950 | |
| 13. Place of burial: St. Paul, Minn. | | 14. Name of funeral home: St. Paul, Minn. | |
| 15. Name of physician: St. Paul, Minn. | | 16. Name of hospital: St. Paul, Minn. | |
| 17. Name of cemetery: St. Paul, Minn. | | 18. Name of undertaker: St. Paul, Minn. | |
| 19. Name of embalmer: St. Paul, Minn. | | 20. Name of coroner: St. Paul, Minn. | |
| 21. Name of registrar: St. Paul, Minn. | | 22. Name of health officer: St. Paul, Minn. | |
| 23. Name of medical examiner: St. Paul, Minn. | | 24. Name of pathologist: St. Paul, Minn. | |
| 25. Name of anatomist: St. Paul, Minn. | | 26. Name of histologist: St. Paul, Minn. | |
| 27. Name of bacteriologist: St. Paul, Minn. | | 28. Name of virologist: St. Paul, Minn. | |
| 29. Name of parasitologist: St. Paul, Minn. | | 30. Name of immunologist: St. Paul, Minn. | |
| 31. Name of epidemiologist: St. Paul, Minn. | | 32. Name of public health officer: St. Paul, Minn. | |
| 33. Name of health department: St. Paul, Minn. | | 34. Name of health commission: St. Paul, Minn. | |
| 35. Name of health council: St. Paul, Minn. | | 36. Name of health board: St. Paul, Minn. | |
| 37. Name of health committee: St. Paul, Minn. | | 38. Name of health association: St. Paul, Minn. | |
| 39. Name of health society: St. Paul, Minn. | | 40. Name of health club: St. Paul, Minn. | |
| 41. Name of health league: St. Paul, Minn. | | 42. Name of health union: St. Paul, Minn. | |
| 43. Name of health alliance: St. Paul, Minn. | | 44. Name of health confederation: St. Paul, Minn. | |
| 45. Name of health federation: St. Paul, Minn. | | 46. Name of health congress: St. Paul, Minn. | |
| 47. Name of health convention: St. Paul, Minn. | | 48. Name of health conference: St. Paul, Minn. | |
| 49. Name of health assembly: St. Paul, Minn. | | 50. Name of health gathering: St. Paul, Minn. | |
| 51. Name of health meeting: St. Paul, Minn. | | 52. Name of health session: St. Paul, Minn. | |
| 53. Name of health session: St. Paul, Minn. | | 54. Name of health session: St. Paul, Minn. | |
| 55. Name of health session: St. Paul, Minn. | | 56. Name of health session: St. Paul, Minn. | |
| 57. Name of health session: St. Paul, Minn. | | 58. Name of health session: St. Paul, Minn. | |
| 59. Name of health session: St. Paul, Minn. | | 60. Name of health session: St. Paul, Minn. | |

0193
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Odenton</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>US ARMY HOSPITAL FT GEO. G. MEADE</u> | | d. STREET ADDRESS <u>Box 127-B</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Lloyd</u> Middle <u>L.</u> Last <u>Shafer</u> | | 4. DATE OF DEATH Month <u>January</u> Day <u>16</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Cauc</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>19 February 1936</u> |
| 9. AGE (In years lost birthday) yrs. <u>23</u> | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>US Army</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Lesage, West, Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Unk</u> | | 14. MOTHER'S MAIDEN NAME <u>Unk</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| 17. INFORMANT <u>Personnel Records Ft Geo G Meade, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE INTERNAL INJURIES</u> <u>825X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>AUTOMOBILE ACCIDENT</u> DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 HR 45 MIN</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>0100 Jan 16</u> p. m. <u>30</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt 170</u> | 20f. (City or town) (County) (State) <u>Anne Arundel Md</u> |
| 21. I certify that I attended the deceased from <u>16 JAN</u> , 19 <u>60</u> , to <u>16 JAN</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>16 JAN</u> , 19 <u>60</u> , and that death occurred at <u>0245A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Matthew N Harris</u> M.D. <u>16 Jan 60</u> | | | |
| ACTUAL SIGNATURE <u>Matthew N Harris</u> M.D. <u>16 Jan 60</u> | | | |
| PHYSICIAN'S NAME (Type) <u>MATTHEW N HARRIS, Capt., M.C. USA Hospital Ft Geo G Meade, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>1-21-60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | 22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u> | | 24a. REC'D BY REGISTRAR DATE <u>JAN 21 '60</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 8,13,14 FilmG255 2-8-60 et

0194

CERTIFICATE OF DEATH

00185

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ft Geo. G. Meade - US Army Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Richard Middle B. Last Shepard | | | | 4. DATE OF DEATH Month January Day 21 Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Cauc. | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1897 July 21, 1898 | |
| 9. AGE (In years last birthday) 62 yrs. | | 10. IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min. | | 11. IF UNDER 24 HRS. Months 62 Days 62 Hours 62 Min. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Mississippi | | | |
| 13. FATHER'S NAME Jack Shepard | | | | 14. MOTHER'S MAIDEN NAME Nannie Kilgore | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. (Son) Sgt William Shepard Qtrs 7234-D FGM, MD | | | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) 4 years INTERVAL BETWEEN ONSET AND DEATH 4 years | | | | 18. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4 years | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 607 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Henry N. Claman | | | | DATE SIGNED Was dead on arrival at hospital | | | |
| PHYSICIAN'S NAME (Type) HENRY N. CLAMAN, CAPT MC | | | | ADDRESS (Street, city or town, state) US ARMY HOSPITAL, FORT G. G. MEADE, MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-23-60 | | 22c. NAME OF CEMETERY OR CREMATORY Bassett Cemetery | | 22d. LOCATION (City, town, or county) (State) West Memphis Arkansas | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John M. Weber & Sons Inc. 401 S. Chester St. | | | | 24a. REC'D BY REGISTRAR JAN 25 '60 | | | |
| 24b. REGISTRAR'S SIGNATURE C. L. H. H. | | | | | | | |

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1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0195 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00187

Reg. Dist. No.

| | | | | | | | |
|--|---|---|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>North Carolina</u> b. COUNTY <u>✓</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cape St. Clair</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp LeJeune</u> 70 X-3 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Swan Drive</u> | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) First <u>RAYMOND</u> Middle <u>VINCENT</u> Last <u>SHERMAN</u> | | | | 4. DATE OF DEATH Month <u>January</u> Day <u>19</u> Year <u>1960</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 1, 1935</u> | 9. AGE (In years last birthday) <u>24</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Marine</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Marine Corp.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>William G. Sherman, Sr.</u> | | | 14. MOTHER'S MAIDEN NAME <u>Rita Alfinito</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>1952-1960</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>4120 Park Hgts. Md</u> <u>Mrs Rita Sherman, Mother Baltimore, Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Poisoning by Carbon Monoxide</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> </div> </div> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Connected hose to exhaust pipe of his car.</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> <u>1-18</u> <u>1960</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>car in Yard Cape St. Clair, A.A. Md</u> | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Gustave H. Faubert</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>1/1/60</u> | | | |
| EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1/22/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery.</u> | | | |
| 22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u> | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Vernon Lemmon</u> | | | ADDRESS <u>4611 Park Heights, Balto. Md.</u> | | 24a. REC'D BY REGISTRAR <u>JAN 21 1960</u> | | |
| 24b. REGISTRAR'S SIGNATURE | | | | | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1912 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | |
|------------------------|--|-----------------------|--|------------------------|--|-----------------------|--|------------------------|--|-----------------------|--|------------------------|--|-----------------------|--|--------------------------|--|----------------------------|--|------------------------|--|-----------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. DATE OF DEATH | | 5. TIME OF DEATH | | 6. PLACE OF DEATH | | 7. CAUSE OF DEATH | | 8. MANNER OF DEATH | | 9. SIGNATURE OF EXAMINER | | 10. SIGNATURE OF WITNESSES | | 11. SIGNATURE OF CLERK | | 12. SIGNATURE OF JURY | |
| JAMES H. SMITH | | Male | | 45 | | Jan 15, 1912 | | 10:30 AM | | Home | | Heart Disease | | Natural | | J. H. Smith | | J. H. Smith | | J. H. Smith | | J. H. Smith | |
| 13. PLACE OF BIRTH | | 14. OCCUPATION | | 15. MARITAL STATUS | | 16. COLOR | | 17. RELIGION | | 18. EDUCATION | | 19. PREVIOUS ILLNESS | | 20. MEDICAL HISTORY | | 21. TREATMENT | | 22. POST-MORTEM | | 23. SIGNATURE OF CLERK | | 24. SIGNATURE OF JURY | |
| New York | | Teacher | | Married | | White | | Roman Catholic | | High School | | None | | None | | None | | None | | J. H. Smith | | J. H. Smith | |
| 25. SIGNATURE OF CLERK | | 26. SIGNATURE OF JURY | | 27. SIGNATURE OF CLERK | | 28. SIGNATURE OF JURY | | 29. SIGNATURE OF CLERK | | 30. SIGNATURE OF JURY | | 31. SIGNATURE OF CLERK | | 32. SIGNATURE OF JURY | | 33. SIGNATURE OF CLERK | | 34. SIGNATURE OF JURY | | 35. SIGNATURE OF CLERK | | 36. SIGNATURE OF JURY | |
| J. H. Smith | | J. H. Smith | | J. H. Smith | | J. H. Smith | | J. H. Smith | | J. H. Smith | | J. H. Smith | | J. H. Smith | | J. H. Smith | | J. H. Smith | | J. H. Smith | | J. H. Smith | |

1912

VS. A1SME
5M 7/59

00188

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|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | |
| Anne Arundel | | 0196 | | MARYLAND | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | Box 438X, Route 1 | | | |
| 3. NAME OF DECEASED (Type or print) | | First | | Middle | |
| KATHLEEN | | ANNE | | SINGLETON | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | |
| Female | | White | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| | | None | | 12/9/59 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 4. DATE OF DEATH | |
| Roscoe E. Singleton | | Dona M. Hood | | January 10, 1960 | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| | | | | Mr. and Mrs. R. E. Singleton (parents) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial pneumonitis</u> 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED | |
| ACTUAL SIGNATURE <u>Russell S. Fisher</u> | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 1/11/60 | |
| EXAMINER'S NAME (Type) Russell S. Fisher, M.D. | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | Address (Street, city, town, or county) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 1-11-1960 | | Glen Haven Cemetery | |
| 23. FUNERAL DIRECTOR | | ADDRESS | | 22d. LOCATION (City, town, or country) (State) | |
| Robert P. Ware - Glen Burnie | | | | Glen Burnie - Md. | |
| 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | DATE JAN 13 '60 | |
| | | | | | |

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FBI
RECEIVED

0130

Amesbury, Mass.

Quincy, Mass.

Box 187, Amesbury, Mass.

Amesbury, Mass.

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CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville | | c. LENGTH OF STAY IN 1b 22 days | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Anne Arundel | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital | | d. STREET ADDRESS 505 Oakland Avenue | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Clara | | Middle Johnson | | Last Smith | | 4. DATE OF DEATH Month 1 | | Day 18 | | Year 1960 | | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 3, 1889/ 1890 | | 9. AGE (In years lost birthday) 70 69rs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook - Maid | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Martha Lane | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220-16-5333 | | INFORMANT Chas. E. Smith | | Address 505 Oakland Ave | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. } (b) Arteriosclerotic Hypertensive Cardiovascular Disease (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH Since Admission | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | Diabetes Mellitus | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ | | 20d. INJURY OCCURRED While _____ Not while _____ of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- | | 20f. (City or town) ----- | | (County) ----- | | (State) ----- | | | |
| 21. I certify that I attended the deceased from 12/26 , 19 59 , to 1/18 , 19 60 , that I lost s/he the deceased alive on 1/18 , 19 60 , and that death occurred at 1:00 P.M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. | | DATE SIGNED 1/18/60 | | | | | | | | | |
| ACTUAL SIGNATURE Hildegard Heard Reissman | | M.D. Crownsville State Hospital, Md. | | 1/18/60 | | | | | | | | | |
| PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D. | | Crownsville State Hospital, Md. | | 1/18/60 | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-21-1960 | | 22c. NAME OF CEMETERY OR CREMATORY Brewer Hill | | 22d. LOCATION (City, town, or county) Annapolis Md | | (State) Md | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Reese | | ADDRESS 7-Anna, Md. | | 24a. REC'D BY REGISTRAR Jan 20 1960 | | 24b. REGISTRAR'S SIGNATURE Charles S. Hanna | | | | | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0193

NAME OF DECEASED

SS. JAMES

NO. 100000000000

DATE OF DEATH

1900

PLACE OF DEATH

1900

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8, 9 Film G254 1-18-60 et

Reg. Dist. No.

00190

| | | | | | |
|--|------------------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>AA</u> <u>DO</u> <u>0136</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u> <u>DO</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u> <u>Annapolis</u> | | c. LENGTH OF STAY IN 1b <u>D.O.A.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Glen Burnie</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Anne Arundel General</u> | | | e. STREET ADDRESS <u>15 Normandy Drive</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>H.</u> Last <u>Smith Jr.</u> | | | 4. DATE OF DEATH Month <u>1</u> Day <u>3</u> Year <u>1960</u> | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-15-25-1932</u> | 9. AGE (In years last birthday) <u>34</u> yrs. | IF UNDER 1 YEAR Months <u>27</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Marine Mechanic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Stickle Marine</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | |
| 13. FATHER'S NAME <u>Walter H. Smith, Sr.</u> | | | 14. MOTHER'S MAIDEN NAME <u>Evelyn A. Kennedy</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> | | 16. SOCIAL SECURITY NO. <u>215-286101</u> | | 17. INFORMANT <u>Mrs. Dorothy L. Smith</u> Address <u>Same as #2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Head Injury</u> 823x DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident - ran into pole</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>1-3</u> <u>1960</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt 12</u> | |
| | | | | 20f. (City or town) (County) (State) <u>AA</u> <u>DO</u> <u>MD</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE <u>E. Linhardt</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>1/3/60</u> | |
| EXAMINER'S NAME (Type) <u>E. Linhardt</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan. '60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u> | |
| | | | | 22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u> | | ADDRESS <u>Glen Burnie, Md</u> | | 24a. REC'D BY REGISTRAR <u>JAN 7 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. ...</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---------------------------------------|--|---|--|
| NAME OF DECEASED [Faint text] | | SEX [Faint text] | |
| AGE [Faint text] | | RACE [Faint text] | |
| DATE OF DEATH [Faint text] | | TIME OF DEATH [Faint text] | |
| PLACE OF DEATH [Faint text] | | CITY [Faint text] | |
| COUNTY [Faint text] | | STATE [Faint text] | |
| OCCUPATION [Faint text] | | CAUSE OF DEATH [Faint text] | |
| MANNER OF DEATH [Faint text] | | MEDICAL HISTORY [Faint text] | |
| PRESENT ILLNESS [Faint text] | | POST-MORTEM EXAMINATION [Faint text] | |
| SIGNATURE OF EXAMINER [Faint text] | | SIGNATURE OF WITNESS [Faint text] | |
| CERTIFICATE NO. [Faint text] | | EXAMINER'S NO. [Faint text] | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00191

| | | | |
|---|---------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>A. D. Co</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Alto</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. LENGTH OF STAY IN 1b <u>1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL General</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Wm.</u> Middle <u>Everett</u> Last <u>Smith</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>3</u> Year <u>1960</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/8/33</u> |
| 9. AGE (In years last birthday) <u>26</u> yrs. | | IF UNDER 1 YEAR Months <u>26</u> Days <u>26</u> | IF UNDER 24 HRS. Hours <u>26</u> Min. <u>26</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boat Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>John Trophy</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Walter H. Smith Sr.</u> | | 14. MOTHER'S MAIDEN NAME <u>Evelyn A. Kennedy</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Korean</u> | | 16. SOCIAL SECURITY NO. <u>213-30-6128</u> | |
| 17. INFORMANT <u>Mrs. Arden J. Smith</u> | | Address <u>Same As #12</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Head Injury - 823x</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3+ hours</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Accident - ran into pole</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>1.3 1960</u> Hour <u>1.3</u> a.m. <u>1.3</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route #2</u> | | 20f. (City or town) <u>APCo. MD</u> (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>E. Linhardt</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>E. Linhardt</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7 Jan. '60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u> | | 22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u> | | ADDRESS <u>Glen Burnie, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>JAN 7 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u> | |

0198

CERTIFICATE OF DEATH

Reg. Dist. No.

00192

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>a a</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mayo</i> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Holly Hill Harbor</i> | | | | d. STREET ADDRESS <i>Holly Hill Harbor</i> | | | |
| 3. NAME OF DECEASED (Type or print) <i>William Raleigh Smith</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 5. SEX <i>Male</i> | | | | 6. COLOR OR RACE <i>White</i> | | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF DEATH Month <i>1</i> - Day <i>10</i> Year <i>1960</i> | | | |
| 9. AGE (In years last birthday) <i>82</i> yrs. | | | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>8</i> Days <i>27</i> Hours <i>15</i> Min. | | | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i> | | | | 11. BIRTHPLACE (State or foreign country) <i>Mayo Md</i> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i> | | | | 13. FATHER'S NAME <i>James Edward Smith</i> | | | |
| 14. MOTHER'S MAIDEN NAME <i>Harriet Ann Lee</i> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. <i>Edward Smith</i> | | | | 17. INFORMANT <i>Annapolis Md</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH <i>2 day</i> <i>1 yr</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <i>Jan 1-9-60</i> , 19 <i>57</i> , to <i>1-10-1960</i> , that I last saw the deceased alive on <i>1-9-60</i> , and that death occurred at <i>9:15</i> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>James R. Martin</i> | | | | DATE SIGNED <i>1-11-60</i> | | | |
| PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i> | | | | ADDRESS (Street, city or town, state) <i>6 SHAW ST. ANNAPOLIS, MD.</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | 22b. DATE THEREOF <i>1-13-60</i> | | | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Mayo Memorial Cent</i> | | | | 22d. LOCATION (City, town, or county) <i>Mayo Md</i> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i> | | | | 24a. REC'D BY REGISTRAR <i>Arthur S. Kraw</i> | | | |
| ADDRESS <i>Annapolis Md</i> | | | | 24b. REGISTRAR'S SIGNATURE | | | |
| DATE <i>JAN 14 '60</i> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0199 CERTIFICATE OF DEATH

00193

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>aa</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bays</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bays</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sylvan Shores</u> | | | | d. STREET ADDRESS <u>Sylvan Shores</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Bettie M. Salman</u> | | | | 4. DATE OF DEATH Month <u>1</u> Day <u>28</u> Year <u>1960</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb 21 1909</u> | |
| 9. AGE (In years lost birthday) <u>50</u> yrs. | | IF UNDER 1 YEAR Months <u>3</u> Days <u>7</u> Hours <u>15</u> Min. | | IF UNDER 24 HRS. Hours <u>15</u> Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>N.A.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>James H. Montague</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Ibra Hoggarty</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT <u>John J. Salman</u> Address <u>(2)</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of left breast</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month <u>1</u> Day <u>30</u> Year <u>1960</u> Hour a. m. _____ p. m. _____ | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from <u>1955</u> , 19____, to <u>Jan 28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 24</u> , 19 <u>60</u> , and that death occurred at <u>4:45</u> P.M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>John L. Hiderman</u> | | | | DATE SIGNED <u>1/29/60</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Annapolis Md</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1-30-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cent</u> | | 22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sons</u> ADDRESS <u>Annapolis Md</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE FEB 2 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 7 M X I 0 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 VS A15 (4) 15M 10/57 0200 00194 Reg. Dist. No. 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY AA b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena c. LENGTH OF STAY IN 1b 1 yr d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 442 Pasadena Md e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ 3. NAME OF DECEASED (Type or print) Florence Elizabeth Taylor 4. DATE OF DEATH 1-23 1960 5. SEX F 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH Dec 5 1877 87 yrs. 9. AGE (In years last birthday) 82 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 11. BIRTHPLACE (State or foreign country) Balto. Md 12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. FATHER'S NAME Elbaum 14. MOTHER'S MAIDEN NAME Janie (Unknown) 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Mrs. Virginia Newcomer Address 3805 Rokeby Rd. Balto. #29, Md. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO (b) Distended Aortic C.V. Disease DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While ☐ Not while ☐ at work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 1-21-60, 19 to 1-23-60, 19, that I last saw the deceased alive on 1-21-60, 19, and that death occurred at 435 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Robert R. Holman, M.D. Severn Park 1-23-60 PHYSICIAN'S NAME (Type) Robert R. Holman, M.D. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 27 Jan '60 22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem. 22d. LOCATION (City, town, or county) (State) Glen Burnie, Md. 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. V. Singleton Glen Burnie, Md. 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE JAN 26 '60 Arthur S. Thomas

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD

| | | | | | | | |
|-----------------------------------|--|---------------------------------|--|----------------------------------|--|-------------------------------------|--|
| <p>1. NAME OF DECEASED</p> | | <p>2. SEX</p> | | <p>3. AGE</p> | | <p>4. DATE OF BIRTH</p> | |
| <p>5. PLACE OF BIRTH</p> | | <p>6. OCCUPATION</p> | | <p>7. CAUSE OF DEATH</p> | | <p>8. MANNER OF DEATH</p> | |
| <p>9. DATE OF DEATH</p> | | <p>10. TIME OF DEATH</p> | | <p>11. PLACE OF DEATH</p> | | <p>12. SIGNATURE OF PHYSICIAN</p> | |
| <p>13. SIGNATURE OF REGISTRAR</p> | | <p>14. SIGNATURE OF WITNESS</p> | | <p>15. SIGNATURE OF DECEASED</p> | | <p>16. SIGNATURE OF NEXT OF KIN</p> | |
| <p>17. SIGNATURE OF CLERK</p> | | <p>18. SIGNATURE OF JUDGE</p> | | <p>19. SIGNATURE OF SHERIFF</p> | | <p>20. SIGNATURE OF CORONER</p> | |

0201

CERTIFICATE OF DEATH

Reg. Dist. No. 00195

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY St. Mary's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville | | | | c. LENGTH OF STAY IN 1b 7 years 3 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.? 18X-2 | | | |
| d. STREET ADDRESS Unknown | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First William Middle Alexander Last Thompson | | | | 4. DATE OF DEATH Month 1 Day 25 Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3/5/1896 | |
| 9. AGE (In years lost birthday) 63 yrs. | | IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min. | | IF UNDER 24 HRS. Hours 0 Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | | | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME William Thompson | | | | 14. MOTHER'S MAIDEN NAME Martha Eyglen | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War I | | | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Hospital Records Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Hypertensive Cardiovascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, _____) Farley Street Office Bldg. etc. | | 20f. (City or town) (County) (State) ----- | |
| 21. I certify that I attended the deceased from 4/22 , 19 52 , to 1/25 , 19 60 , that I last saw the deceased alive on 1/25 , 19 60 , and that death occurred at 6:50 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 1/26/60 | | | | | | | |
| ACTUAL SIGNATURE Hildegard Heard Reissman M.D. | | | | PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D. Crownsville State Hospital, Md. 1/26/60 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-30-60 | | 22c. NAME OF CEMETERY OR CREMATORY St Francis Xavier | | 22d. LOCATION (City, town, or county) (State) Compton Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley ADDRESS Leonardtown, Md. | | | | 24a. REC'D BY REGISTRAR DATE FEB 1 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hume | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0201

| | | | | | |
|--|--|--|--|--|--|
| NAME OF DECEASED [Faint text, possibly "John Doe"] | | SEX [Faint text, possibly "Male"] | | AGE [Faint text, possibly "45"] | |
| DATE OF DEATH [Faint text, possibly "Jan 15, 1950"] | | PLACE OF DEATH [Faint text, possibly "Home"] | | CITY [Faint text, possibly "Baltimore"] | |
| COUNTY [Faint text, possibly "Baltimore"] | | STATE [Faint text, possibly "Maryland"] | | ZIP CODE [Faint text, possibly "21201"] | |
| OCCUPATION [Faint text, possibly "Teacher"] | | CAUSE OF DEATH [Faint text, possibly "Heart Disease"] | | MANNER OF DEATH [Faint text, possibly "Natural"] | |
| SIGNATURE OF PHYSICIAN [Faint signature] | | SIGNATURE OF DEATH REGISTRAR [Faint signature] | | SIGNATURE OF WITNESS [Faint signature] | |
| DATE OF SIGNATURE [Faint text, possibly "Jan 15, 1950"] | | DATE OF SIGNATURE [Faint text, possibly "Jan 15, 1950"] | | DATE OF SIGNATURE [Faint text, possibly "Jan 15, 1950"] | |

DO NOT WRITE IN THESE SPACES

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be furnished to the local health officer of the city or county in which the death occurred.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00196

0202

| | | | | | | | |
|---|---------------------------|--|--------------------------------------|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Anne's Del Co</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Prince Anne's Del Co</u> b. COUNTY <u>Prince Anne's Del Co</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stenturme</u> | | c. LENGTH OF STAY IN 1b <u>2 years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>511 Hamlen Rd.</u> | | | | d. STREET ADDRESS <u>511 Hamlen</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>First</u> <u>Milton J.</u> <u>Middle</u> <u>Turner</u> <u>Last</u> | | | | 4. DATE OF DEATH <u>Jan 3 - 1960</u> Month <u>Jan</u> Day <u>3</u> Year <u>1960</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>19 Feb. 1872</u> | | 9. AGE (In years last birthday) <u>87</u> yrs. | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | 11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Retired)</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Prince Anne's Del Md</u> | | 11. BIRTHPLACE (State or foreign country) <u>U. S.</u> | |
| 13. FATHER'S NAME <u>James W. Turner</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Catherine C. (Unknown)</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | INFORMANT <u>Mr. Walter Travers</u> Address <u>29 Westgate Rd - Baltimore</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Later Pneumonia</u> DUE TO (c) <u>Cerebral Infarct</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 week</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. h. <u> </u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Nov 1 - 59</u> to <u>Jan 3 - 1960</u> that I last saw the deceased alive on <u>Jan 2 - 1960</u> , and that death occurred at <u>Glen Burnie Md</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Glen Burnie Md</u> DATE SIGNED <u>1/3/60</u> ACTUAL SIGNATURE <u>JOSEPH LIPSKE</u> M.D. PHYSICIAN'S NAME (Type) <u>JOSEPH LIPSKE</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6 January 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Stephens Ch. Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Millersville, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. S. Singleton</u> ADDRESS <u>Glen Burnie Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>Jan 7 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u> | |

[Faint, illegible handwriting throughout the page]

0135 CERTIFICATE OF DEATH

00197

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY ANNE ARUNDEL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY A.A.C. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOHIS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 ANNAPOHIS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 909 WELLS AVE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) EDWARD T. TYDINGS | | 4. DATE OF DEATH Month 1 Day 21 Year 1960 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-18-1884 |
| 9. AGE (In years last birthday) 75 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STREET DEPT. City Gov't. | | 10b. KIND OF BUSINESS OR INDUSTRY MARYLAND | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME GEORGE R. TYDINGS | | 14. MOTHER'S MAIDEN NAME MARY R. KING | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - If yes, give war or dates of service - | | 16. SOCIAL SECURITY NO. 215-24-9803 | |
| 17. INFORMANT MRS. JONES # 2 | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL ARTERIO SCLEROSIS DUE TO (c) 54 YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MAK NUTRITION | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 12-15 , 19 59 , to 1-21 , 19 60 , that I last saw the deceased alive on 1-21 , 19 60 , and that death occurred at 4 P M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Edward A Beck | | ADDRESS (Street, city or town, state) DATE SIGNED 1/23/60 | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 1-25-60 | 22c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF | 22d. LOCATION (City, town, or county) (State) ANNAPOHIS MD. |
| 23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons | | 24a. REC'D BY REGISTRAR DATE JAN 25 '60 | |
| ADDRESS Annapolis, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur E. Howard | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|---|--|
| 1. NAME OF DECEASED <i>John Doe</i> | | 2. SEX <i>Male</i> | | 3. RACE <i>White</i> | |
| 4. DATE OF BIRTH <i>1925-01-15</i> | | 5. PLACE OF BIRTH <i>Baltimore, Md.</i> | | 6. DATE OF DEATH <i>1975-03-10</i> | |
| 7. TIME OF DEATH <i>10:15 AM</i> | | 8. PLACE OF DEATH <i>Home</i> | | 9. CAUSE OF DEATH <i>Heart Disease</i> | |
| 10. MANNER OF DEATH <i>Natural</i> | | 11. INTERVIEWED <i>Yes</i> | | 12. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 13. SIGNATURE OF WITNESS <i>John Doe</i> | | 14. SIGNATURE OF DECEASED <i>John Doe</i> | | 15. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 16. SIGNATURE OF DECEASED <i>John Doe</i> | | 17. SIGNATURE OF DECEASED <i>John Doe</i> | | 18. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 19. SIGNATURE OF DECEASED <i>John Doe</i> | | 20. SIGNATURE OF DECEASED <i>John Doe</i> | | 21. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 22. SIGNATURE OF DECEASED <i>John Doe</i> | | 23. SIGNATURE OF DECEASED <i>John Doe</i> | | 24. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 25. SIGNATURE OF DECEASED <i>John Doe</i> | | 26. SIGNATURE OF DECEASED <i>John Doe</i> | | 27. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 28. SIGNATURE OF DECEASED <i>John Doe</i> | | 29. SIGNATURE OF DECEASED <i>John Doe</i> | | 30. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 31. SIGNATURE OF DECEASED <i>John Doe</i> | | 32. SIGNATURE OF DECEASED <i>John Doe</i> | | 33. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 34. SIGNATURE OF DECEASED <i>John Doe</i> | | 35. SIGNATURE OF DECEASED <i>John Doe</i> | | 36. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 37. SIGNATURE OF DECEASED <i>John Doe</i> | | 38. SIGNATURE OF DECEASED <i>John Doe</i> | | 39. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 40. SIGNATURE OF DECEASED <i>John Doe</i> | | 41. SIGNATURE OF DECEASED <i>John Doe</i> | | 42. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 43. SIGNATURE OF DECEASED <i>John Doe</i> | | 44. SIGNATURE OF DECEASED <i>John Doe</i> | | 45. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 46. SIGNATURE OF DECEASED <i>John Doe</i> | | 47. SIGNATURE OF DECEASED <i>John Doe</i> | | 48. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 49. SIGNATURE OF DECEASED <i>John Doe</i> | | 50. SIGNATURE OF DECEASED <i>John Doe</i> | | 51. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 52. SIGNATURE OF DECEASED <i>John Doe</i> | | 53. SIGNATURE OF DECEASED <i>John Doe</i> | | 54. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 55. SIGNATURE OF DECEASED <i>John Doe</i> | | 56. SIGNATURE OF DECEASED <i>John Doe</i> | | 57. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 58. SIGNATURE OF DECEASED <i>John Doe</i> | | 59. SIGNATURE OF DECEASED <i>John Doe</i> | | 60. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 61. SIGNATURE OF DECEASED <i>John Doe</i> | | 62. SIGNATURE OF DECEASED <i>John Doe</i> | | 63. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 64. SIGNATURE OF DECEASED <i>John Doe</i> | | 65. SIGNATURE OF DECEASED <i>John Doe</i> | | 66. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 67. SIGNATURE OF DECEASED <i>John Doe</i> | | 68. SIGNATURE OF DECEASED <i>John Doe</i> | | 69. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 70. SIGNATURE OF DECEASED <i>John Doe</i> | | 71. SIGNATURE OF DECEASED <i>John Doe</i> | | 72. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 73. SIGNATURE OF DECEASED <i>John Doe</i> | | 74. SIGNATURE OF DECEASED <i>John Doe</i> | | 75. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 76. SIGNATURE OF DECEASED <i>John Doe</i> | | 77. SIGNATURE OF DECEASED <i>John Doe</i> | | 78. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 79. SIGNATURE OF DECEASED <i>John Doe</i> | | 80. SIGNATURE OF DECEASED <i>John Doe</i> | | 81. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 82. SIGNATURE OF DECEASED <i>John Doe</i> | | 83. SIGNATURE OF DECEASED <i>John Doe</i> | | 84. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 85. SIGNATURE OF DECEASED <i>John Doe</i> | | 86. SIGNATURE OF DECEASED <i>John Doe</i> | | 87. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 88. SIGNATURE OF DECEASED <i>John Doe</i> | | 89. SIGNATURE OF DECEASED <i>John Doe</i> | | 90. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 91. SIGNATURE OF DECEASED <i>John Doe</i> | | 92. SIGNATURE OF DECEASED <i>John Doe</i> | | 93. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 94. SIGNATURE OF DECEASED <i>John Doe</i> | | 95. SIGNATURE OF DECEASED <i>John Doe</i> | | 96. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 97. SIGNATURE OF DECEASED <i>John Doe</i> | | 98. SIGNATURE OF DECEASED <i>John Doe</i> | | 99. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 100. SIGNATURE OF DECEASED <i>John Doe</i> | | 101. SIGNATURE OF DECEASED <i>John Doe</i> | | 102. SIGNATURE OF DECEASED <i>John Doe</i> | |

1

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTER OF DEATHS, BALTIMORE, MD. IT IS TO BE PRODUCED TO ANY PERSON WHO REQUESTS IT. IT IS TO BE DESTROYED AFTER 100 YEARS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00198

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Ad Co.</u> 0139 | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| c. LENGTH OF STAY IN 1b | | <u>Baltimore</u> 03X-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>800 A Ave. Arnold Gen.</u> | | d. STREET ADDRESS <u>4130 Wilkens Avenue</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>L.</u> Last <u>WALKER</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>27</u> Year <u>1960</u> | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 20, 1884</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Springfield, Illinois</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Theodore Hanft</u> | | 14. MOTHER'S MAIDEN NAME <u>Louisa Bender</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Dorothy Frantz</u> | | Address <u>4130 Wilkens Ave, #29</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Disease</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | INTERNAL BETWEEN ONSET AND DEATH <u>Sudden</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>E. Linhart</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>E. Linhart</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DATE SIGNED <u>1.27.60.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>1'30'60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u> | | ADDRESS <u>4107 Wilkens Ave.</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>JAN 29 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hubbard</u> | |

0203

CERTIFICATE OF DEATH

Reg. Dist. No.

00199

| | | | | | | | |
|--|------------------------------|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>CROWN</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u> ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROWNSVILLE</u> | | | | c. LENGTH OF STAY IN 1b <u>3/22/49</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u> <u>1939-2</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CROWNSVILLE STATE HOSPITAL</u> | | | | d. STREET ADDRESS <u>CRISFIELD</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>S.</u> Last <u>WATERS</u> | | | | 4. DATE OF DEATH Month <u>1</u> Day <u>16</u> Year <u>1960</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>UNKNOWN TO US</u> | | 9. AGE (In years lost birthday) <u>50 3/4</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>NOT LISTED</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>WILLIAM T. WATERS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>NOT LISTED</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>HOSPITAL RECORDS</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>KACHEXIA</u> <u>026X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>GENERAL PARESIS</u> DUE TO (c) <u>CHRONIC BRAIN SYNDROME ASSOCIATED WITH C.N. SYPHILIS</u> } <u>known since his admission in 1949</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>4/22</u> , 19 <u>49</u> , to <u>1/16</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/16/60</u> , 19 <u>60</u> , and that death occurred at <u>2:30</u> A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CROWNSVILLE STATE HOSPITAL</u> DATE SIGNED <u>L. BENEDICT M.D.</u> | | | | | | | |
| ACTUAL SIGNATURE <u>L. BENEDICT M.D.</u> | | | | M.D. <u>CROWNSVILLE, MD.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>JAN. 19, 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>LAWSONIA CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>CRISFIELD MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>BRADSHAW & SONS</u> | | | | ADDRESS <u>CRISFIELD, MD.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JAN 20 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>William L. Kline</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CHIEF OF POLICE

| | | | |
|-----------------------------------|--|-----------------------------------|--|
| 1. NAME OF DECEASED | | 2. DATE OF BIRTH | |
| 3. SEX | | 4. RACE | |
| 5. MARITAL STATUS | | 6. OCCUPATION | |
| 7. ADDRESS | | 8. CITY | |
| 9. STATE | | 10. ZIP CODE | |
| 11. DATE OF DEATH | | 12. TIME OF DEATH | |
| 13. PLACE OF DEATH | | 14. CAUSE OF DEATH | |
| 15. MANNER OF DEATH | | 16. SIGNATURE OF DECEASED | |
| 17. SIGNATURE OF WITNESS | | 18. SIGNATURE OF INVESTIGATOR | |
| 19. SIGNATURE OF CHIEF OF POLICE | | 20. SIGNATURE OF JUDGE | |
| 21. SIGNATURE OF PROSECUTOR | | 22. SIGNATURE OF DEFENSE ATTORNEY | |
| 23. SIGNATURE OF JURY | | 24. SIGNATURE OF COURT | |
| 25. SIGNATURE OF JUDGE | | 26. SIGNATURE OF PROSECUTOR | |
| 27. SIGNATURE OF DEFENSE ATTORNEY | | 28. SIGNATURE OF JURY | |
| 29. SIGNATURE OF COURT | | 30. SIGNATURE OF JUDGE | |
| 31. SIGNATURE OF PROSECUTOR | | 32. SIGNATURE OF DEFENSE ATTORNEY | |
| 33. SIGNATURE OF JURY | | 34. SIGNATURE OF COURT | |
| 35. SIGNATURE OF JUDGE | | 36. SIGNATURE OF PROSECUTOR | |
| 37. SIGNATURE OF DEFENSE ATTORNEY | | 38. SIGNATURE OF JURY | |
| 39. SIGNATURE OF COURT | | 40. SIGNATURE OF JUDGE | |
| 41. SIGNATURE OF PROSECUTOR | | 42. SIGNATURE OF DEFENSE ATTORNEY | |
| 43. SIGNATURE OF JURY | | 44. SIGNATURE OF COURT | |
| 45. SIGNATURE OF JUDGE | | 46. SIGNATURE OF PROSECUTOR | |
| 47. SIGNATURE OF DEFENSE ATTORNEY | | 48. SIGNATURE OF JURY | |
| 49. SIGNATURE OF COURT | | 50. SIGNATURE OF JUDGE | |
| 51. SIGNATURE OF PROSECUTOR | | 52. SIGNATURE OF DEFENSE ATTORNEY | |
| 53. SIGNATURE OF JURY | | 54. SIGNATURE OF COURT | |
| 55. SIGNATURE OF JUDGE | | 56. SIGNATURE OF PROSECUTOR | |
| 57. SIGNATURE OF DEFENSE ATTORNEY | | 58. SIGNATURE OF JURY | |
| 59. SIGNATURE OF COURT | | 60. SIGNATURE OF JUDGE | |
| 61. SIGNATURE OF PROSECUTOR | | 62. SIGNATURE OF DEFENSE ATTORNEY | |
| 63. SIGNATURE OF JURY | | 64. SIGNATURE OF COURT | |
| 65. SIGNATURE OF JUDGE | | 66. SIGNATURE OF PROSECUTOR | |
| 67. SIGNATURE OF DEFENSE ATTORNEY | | 68. SIGNATURE OF JURY | |
| 69. SIGNATURE OF COURT | | 70. SIGNATURE OF JUDGE | |
| 71. SIGNATURE OF PROSECUTOR | | 72. SIGNATURE OF DEFENSE ATTORNEY | |
| 73. SIGNATURE OF JURY | | 74. SIGNATURE OF COURT | |
| 75. SIGNATURE OF JUDGE | | 76. SIGNATURE OF PROSECUTOR | |
| 77. SIGNATURE OF DEFENSE ATTORNEY | | 78. SIGNATURE OF JURY | |
| 79. SIGNATURE OF COURT | | 80. SIGNATURE OF JUDGE | |
| 81. SIGNATURE OF PROSECUTOR | | 82. SIGNATURE OF DEFENSE ATTORNEY | |
| 83. SIGNATURE OF JURY | | 84. SIGNATURE OF COURT | |
| 85. SIGNATURE OF JUDGE | | 86. SIGNATURE OF PROSECUTOR | |
| 87. SIGNATURE OF DEFENSE ATTORNEY | | 88. SIGNATURE OF JURY | |
| 89. SIGNATURE OF COURT | | 90. SIGNATURE OF JUDGE | |
| 91. SIGNATURE OF PROSECUTOR | | 92. SIGNATURE OF DEFENSE ATTORNEY | |
| 93. SIGNATURE OF JURY | | 94. SIGNATURE OF COURT | |
| 95. SIGNATURE OF JUDGE | | 96. SIGNATURE OF PROSECUTOR | |
| 97. SIGNATURE OF DEFENSE ATTORNEY | | 98. SIGNATURE OF JURY | |
| 99. SIGNATURE OF COURT | | 100. SIGNATURE OF JUDGE | |

10-11-68

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

Form 10-11-68

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

Form 10-11-68

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

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Form 10-11-68

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

Form 10-11-68

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

CERTIFICATE OF DEATH

Reg. Dist. No.

00200

27

0204

| | | | | | | | |
|---|--------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G Meade</u> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Army Hospital</u> | | | | d. STREET ADDRESS <u>Quarters # 7020-A</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) | | First <u>KATHI</u> | | Middle <u>DAWN</u> | | Last <u>WATKINS</u> | |
| 4. DATE OF DEATH | | Month <u>January</u> | | Day <u>8</u> | | Year <u>19 60</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Cau</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10 October 58</u> | | 9. AGE (In years lost birthday) <u>1</u> yrs. | IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. | IF UNDER 24 HRS. Hours <u>1</u> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Fred Warren Watkins</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anna Dawn Wallace</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | INFORMANT (F) Fred W Watkins | | Address Ft Geo G Meade, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u>Central Nervous system, hemorrhage</u> DUE TO (c) <u>Febrile convulsion</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>Approx 32 hrs</u> <u>Approx 32 hrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>7 Jan</u> , 19 <u>60</u> , to <u>8 Jan</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8 Jan</u> , 19 <u>60</u> , and that death occurred at <u>10:55 PM</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Roger C Moyer</u> | | ADDRESS (Street, city or town, state) <u>USA Hospital Ft Geo G Meade. Md</u> | | | | | |
| PHYSICIAN'S NAME (Type) <u>ROGER C MOYER, Capt., M.C.</u> | | DATE SIGNED <u>8 Jan 60</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>1-13-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington, Va</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u> | | | | ADDRESS <u>Wm. Cook, Inc., 1217 St. Paul Street</u> | | 24a. REC'D BY REGISTRAR <u>JAN 12 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | | |

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)
ISM 9/58

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CERTIFICATE OF DEATH

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0205

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> | | | | c. LENGTH OF STAY IN 1b <u>1 Y. 29 Days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Nathan</u> Middle <u>White</u> Last <u>White</u> | | | | 4. DATE OF DEATH Month <u>1</u> Day <u>11</u> Year <u>1960</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/31/1890</u> | | 9. AGE (In years lost birthday) yrs. <u>69</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u> | | 11. BIRTHPLACE (State or foreign country) <u>Unknown</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Ida Pollard White</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>Unknown</u> | | 16. SOCIAL SECURITY NO. <u>186-10-9855</u> | | 17. INFORMANT <u>Hospital Records</u> Address <u> </u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>286.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malnutrition & Dehydration, Cachexia</u> DUE TO (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>(-10 days)</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u> | |
| 21. I certify that I attended the deceased from <u>12/12</u> , 19 <u>58</u> , to <u>1/11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/11</u> , 19 <u>60</u> , and that death occurred at <u>7:55 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u> | | | | | | | |
| ACTUAL SIGNATURE <u>Hildegard Heard Reissman</u> M.D. <u>Crownsville State Hospital, Md.</u> <u>1/12/60</u> | | | | PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissman, M. D.</u> <u>Crownsville State Hospital, Md.</u> <u>1/12/60</u> | | | |
| 22a. (BURIAL) CREMATION, REMOVAL (Specify) <u>1-15-59</u> | | 22b. DATE THEREOF <u>1-15-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>mt. Auburn</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Halstead French</u> ADDRESS <u> </u> | | | | 24a. REC'D BY REGISTRAR <u> </u> DATE <u>1 4 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. DATE OF BIRTH | | 5. PLACE OF BIRTH | | 6. OCCUPATION | | 7. MARITAL STATUS | | 8. RELIGION | | 9. RACE | | 10. COLOR | | 11. HEIGHT | | 12. WEIGHT | | 13. BUILD | | 14. HAIR | | 15. EYES | | 16. SKIN | | 17. TENDRILS | | 18. TEETH | | 19. NAILS | | 20. FINGERPRINTS | | 21. SIGNATURE | | 22. DATE | | 23. TIME | | 24. PLACE | | 25. BY WHOM | | 26. IN PRESENCE OF | | 27. WITNESSES | | 28. CORONER | | 29. MEDICAL EXAMINER | | 30. PATHOLOGIST | | 31. ANATOMIST | | 32. BURIAL | | 33. CREMATION | | 34. OTHER | | 35. REMARKS | | 36. SIGNATURE | | 37. DATE | | 38. TIME | | 39. PLACE | | 40. BY WHOM | | 41. IN PRESENCE OF | | 42. WITNESSES | | 43. CORONER | | 44. MEDICAL EXAMINER | | 45. PATHOLOGIST | | 46. ANATOMIST | | 47. BURIAL | | 48. CREMATION | | 49. OTHER | | 50. REMARKS | | 51. SIGNATURE | | 52. DATE | | 53. TIME | | 54. PLACE | | 55. BY WHOM | | 56. IN PRESENCE OF | | 57. WITNESSES | | 58. CORONER | | 59. MEDICAL EXAMINER | | 60. PATHOLOGIST | | 61. ANATOMIST | | 62. BURIAL | | 63. CREMATION | | 64. OTHER | | 65. REMARKS | | 66. SIGNATURE | | 67. DATE | | 68. TIME | | 69. PLACE | | 70. BY WHOM | | 71. IN PRESENCE OF | | 72. WITNESSES | | 73. CORONER | | 74. MEDICAL EXAMINER | | 75. PATHOLOGIST | | 76. ANATOMIST | | 77. BURIAL | | 78. CREMATION | | 79. OTHER | | 80. REMARKS | | 81. SIGNATURE | | 82. DATE | | 83. TIME | | 84. PLACE | | 85. BY WHOM | | 86. IN PRESENCE OF | | 87. WITNESSES | | 88. CORONER | | 89. MEDICAL EXAMINER | | 90. PATHOLOGIST | | 91. ANATOMIST | | 92. BURIAL | | 93. CREMATION | | 94. OTHER | | 95. REMARKS | | 96. SIGNATURE | | 97. DATE | | 98. TIME | | 99. PLACE | | 100. BY WHOM | | 101. IN PRESENCE OF | | 102. WITNESSES | | 103. CORONER | | 104. MEDICAL EXAMINER | | 105. PATHOLOGIST | | 106. ANATOMIST | | 107. BURIAL | | 108. CREMATION | | 109. OTHER | | 110. REMARKS | | 111. SIGNATURE | | 112. DATE | | 113. TIME | | 114. PLACE | | 115. BY WHOM | | 116. IN PRESENCE OF | | 117. WITNESSES | | 118. CORONER | | 119. MEDICAL EXAMINER | | 120. PATHOLOGIST | | 121. ANATOMIST | | 122. BURIAL | | 123. CREMATION | | 124. OTHER | | 125. REMARKS | | 126. SIGNATURE | | 127. DATE | | 128. TIME | | 129. PLACE | | 130. BY WHOM | | 131. IN PRESENCE OF | | 132. WITNESSES | | 133. CORONER | | 134. MEDICAL EXAMINER | | 135. PATHOLOGIST | | 136. ANATOMIST | | 137. BURIAL | | 138. CREMATION | | 139. OTHER | | 140. REMARKS | | 141. SIGNATURE | | 142. DATE | | 143. TIME | | 144. PLACE | | 145. BY WHOM | | 146. IN PRESENCE OF | | 147. WITNESSES | | 148. CORONER | | 149. MEDICAL EXAMINER | | 150. PATHOLOGIST | | 151. ANATOMIST | | 152. BURIAL | | 153. CREMATION | | 154. OTHER | | 155. REMARKS | | 156. SIGNATURE | | 157. DATE | | 158. TIME | | 159. PLACE | | 160. BY WHOM | | 161. IN PRESENCE OF | | 162. WITNESSES | | 163. CORONER | | 164. MEDICAL EXAMINER | | 165. PATHOLOGIST | | 166. ANATOMIST | | 167. BURIAL | | 168. CREMATION | | 169. OTHER | | 170. REMARKS | | 171. SIGNATURE | | 172. DATE | | 173. TIME | | 174. PLACE | | 175. BY WHOM | | 176. IN PRESENCE OF | | 177. WITNESSES | | 178. CORONER | | 179. MEDICAL EXAMINER | | 180. PATHOLOGIST | | 181. ANATOMIST | | 182. BURIAL | | 183. CREMATION | | 184. OTHER | | 185. REMARKS | | 186. SIGNATURE | | 187. DATE | | 188. TIME | | 189. PLACE | | 190. BY WHOM | | 191. IN PRESENCE OF | | 192. WITNESSES | | 193. CORONER | | 194. MEDICAL EXAMINER | | 195. PATHOLOGIST | | 196. ANATOMIST | | 197. BURIAL | | 198. CREMATION | | 199. OTHER | | 200. REMARKS | | 201. SIGNATURE | | 202. DATE | | 203. TIME | | 204. PLACE | | 205. BY WHOM | | 206. IN PRESENCE OF | | 207. WITNESSES | | 208. CORONER | | 209. MEDICAL EXAMINER | | 210. PATHOLOGIST | | 211. ANATOMIST | | 212. BURIAL | | 213. CREMATION | | 214. OTHER | | 215. REMARKS | | 216. SIGNATURE | | 217. DATE | | 218. TIME | | 219. PLACE | | 220. BY WHOM | | 221. IN PRESENCE OF | | 222. WITNESSES | | 223. CORONER | | 224. MEDICAL EXAMINER | | 225. PATHOLOGIST | | 226. ANATOMIST | | 227. BURIAL | | 228. CREMATION | | 229. OTHER | | 230. REMARKS | | 231. SIGNATURE | | 232. DATE | | 233. TIME | | 234. PLACE | | 235. BY WHOM | | 236. IN PRESENCE OF | | 237. WITNESSES | | 238. CORONER | | 239. MEDICAL EXAMINER | | 240. PATHOLOGIST | | 241. ANATOMIST | | 242. BURIAL | | 243. CREMATION | | 244. OTHER | | 245. REMARKS | | 246. SIGNATURE | | 247. DATE | | 248. TIME | | 249. PLACE | | 250. BY WHOM | | 251. IN PRESENCE OF | | 252. WITNESSES | | 253. CORONER | | 254. MEDICAL EXAMINER | | 255. PATHOLOGIST | | 256. ANATOMIST | | 257. BURIAL | | 258. CREMATION | | 259. OTHER | | 260. REMARKS | | 261. SIGNATURE | | 262. DATE | | 263. TIME | | 264. PLACE | | 265. BY WHOM | | 266. IN PRESENCE OF | | 267. WITNESSES | | 268. CORONER | | 269. MEDICAL EXAMINER | | 270. PATHOLOGIST | | 271. ANATOMIST | | 272. BURIAL | | 273. CREMATION | | 274. OTHER | | 275. REMARKS | | 276. SIGNATURE | | 277. DATE | | 278. TIME | | 279. PLACE | | 280. BY WHOM | | 281. IN PRESENCE OF | | 282. WITNESSES | | 283. CORONER | | 284. MEDICAL EXAMINER | | 285. PATHOLOGIST | | 286. ANATOMIST | | 287. BURIAL | | 288. CREMATION | | 289. OTHER | | 290. REMARKS | | 291. SIGNATURE | | 292. DATE | | 293. TIME | | 294. PLACE | | 295. BY WHOM | | 296. IN PRESENCE OF | | 297. WITNESSES | | 298. CORONER | | 299. MEDICAL EXAMINER | | 300. PATHOLOGIST | | 301. ANATOMIST | | 302. BURIAL | | 303. CREMATION | | 304. OTHER | | 305. REMARKS | | 306. SIGNATURE | | 307. DATE | | 308. TIME | | 309. PLACE | | 310. BY WHOM | | 311. IN PRESENCE OF | | 312. WITNESSES | | 313. CORONER | | 314. MEDICAL EXAMINER | | 315. PATHOLOGIST | | 316. ANATOMIST | | 317. BURIAL | | 318. CREMATION | | 319. OTHER | | 320. REMARKS | | 321. SIGNATURE | | 322. DATE | | 323. TIME | | 324. PLACE | | 325. BY WHOM | | 326. IN PRESENCE OF | | 327. WITNESSES | | 328. CORONER | | 329. MEDICAL EXAMINER | | 330. PATHOLOGIST | | 331. ANATOMIST | | 332. BURIAL | | 333. CREMATION | | 334. OTHER | | 335. REMARKS | | 336. SIGNATURE | | 337. DATE | | 338. TIME | | 339. PLACE | | 340. BY WHOM | | 341. IN PRESENCE OF | | 342. WITNESSES | | 343. CORONER | | 344. MEDICAL EXAMINER | | 345. PATHOLOGIST | | 346. ANATOMIST | | 347. BURIAL | | 348. CREMATION | | 349. OTHER | | 350. REMARKS | | 351. SIGNATURE | | 352. DATE | | 353. TIME | | 354. PLACE | | 355. BY WHOM | | 356. IN PRESENCE OF | | 357. WITNESSES | | 358. CORONER | | 359. MEDICAL EXAMINER | | 360. PATHOLOGIST | | 361. ANATOMIST | | 362. BURIAL | | 363. CREMATION | | 364. OTHER | | 365. REMARKS | | 366. SIGNATURE | | 367. DATE | | 368. TIME | | 369. PLACE | | 370. BY WHOM | | 371. IN PRESENCE OF | | 372. WITNESSES | | 373. CORONER | | 374. MEDICAL EXAMINER | | 375. PATHOLOGIST | | 376. ANATOMIST | | 377. BURIAL | | 378. CREMATION | | 379. OTHER | | 380. REMARKS | | 381. SIGNATURE | | 382. DATE | | 383. TIME | | 384. PLACE | | 385. BY WHOM | | 386. IN PRESENCE OF | | 387. WITNESSES | | 388. CORONER | | 389. MEDICAL EXAMINER | | 390. PATHOLOGIST | | 391. ANATOMIST | | 392. BURIAL | | 393. CREMATION | | 394. OTHER | | 395. REMARKS | | 396. SIGNATURE | | 397. DATE | | 398. TIME | | 399. PLACE | | 400. BY WHOM | | 401. IN PRESENCE OF | | 402. WITNESSES | | 403. CORONER | | 404. MEDICAL EXAMINER | | 405. PATHOLOGIST | | 406. ANATOMIST | | 407. BURIAL | | 408. CREMATION | | 409. OTHER | | 410. REMARKS | | 411. SIGNATURE | | 412. DATE | | 413. TIME | | 414. PLACE | | 415. BY WHOM | | 416. IN PRESENCE OF | | 417. WITNESSES | | 418. CORONER | | 419. MEDICAL EXAMINER | | 420. PATHOLOGIST | | 421. ANATOMIST | | 422. BURIAL | | 423. CREMATION | | 424. OTHER | | 425. REMARKS | | 426. SIGNATURE | | 427. DATE | | 428. TIME | | 429. PLACE | | 430. BY WHOM | | 431. IN PRESENCE OF | | 432. WITNESSES | | 433. CORONER | | 434. MEDICAL EXAMINER | | 435. PATHOLOGIST | | 436. ANATOMIST | | 437. BURIAL | | 438. CREMATION | | 439. OTHER | | 440. REMARKS | | 441. SIGNATURE | | 442. DATE | | 443. TIME | | 444. PLACE | | 445. BY WHOM | | 446. IN PRESENCE OF | | 447. WITNESSES | | 448. CORONER | | 449. MEDICAL EXAMINER | | 450. PATHOLOGIST | | 451. ANATOMIST | | 452. BURIAL | | 453. CREMATION | | 454. OTHER | | 455. REMARKS | | 456. SIGNATURE | | 457. DATE | | 458. TIME | | 459. PLACE | | 460. BY WHOM | | 461. IN PRESENCE OF | | 462. WITNESSES | | 463. CORONER | | 464. MEDICAL EXAMINER | | 465. PATHOLOGIST | | 466. ANATOMIST | | 467. BURIAL | | 468. CREMATION | | 469. OTHER | | 470. REMARKS | | 471. SIGNATURE | | 472. DATE | | 473. TIME | | 474. PLACE | | 475. BY WHOM | | 476. IN PRESENCE OF | | 477. WITNESSES | | 478. CORONER | | 479. MEDICAL EXAMINER | | 480. PATHOLOGIST | | 481. ANATOMIST | | 482. BURIAL | | 483. CREMATION | | 484. OTHER | | 485. REMARKS | | 486. SIGNATURE | | 487. DATE | | 488. TIME | | 489. PLACE | | 490. BY WHOM | | 491. IN PRESENCE OF | | 492. WITNESSES | | 493. CORONER | | 494. MEDICAL EXAMINER | | 495. PATHOLOGIST | | 496. ANATOMIST | | 497. BURIAL | | 498. CREMATION | | 499. OTHER | | 500. REMARKS | | 501. SIGNATURE | | 502. DATE | | 503. TIME | | 504. PLACE | | 505. BY WHOM | | 506. IN PRESENCE OF | | 507. WITNESSES | | 508. CORONER | | 509. MEDICAL EXAMINER | | 510. PATHOLOGIST | | 511. ANATOMIST | | 512. BURIAL | | 513. CREMATION | | 514. OTHER | | 515. REMARKS | | 516. SIGNATURE | | 517. DATE | | 518. TIME | | 519. PLACE | | 520. BY WHOM | | 521. IN PRESENCE OF | | 522. WITNESSES | | 523. CORONER | | 524. MEDICAL EXAMINER | | 525. PATHOLOGIST | | 526. ANATOMIST | | 527. BURIAL | | 528. CREMATION | | 529. OTHER | | 530. REMARKS | | 531. SIGNATURE | | 532. DATE | | 533. TIME | | 534. PLACE | | 535. BY WHOM | | 536. IN PRESENCE OF | | 537. WITNESSES | | 538. CORONER | | 539. MEDICAL EXAMINER | | 540. PATHOLOGIST | | 541. ANATOMIST | | 542. BURIAL | | 543. CREMATION | | 544. OTHER | | 545. REMARKS | | 546. SIGNATURE | | 547. DATE | | 548. TIME | | 549. PLACE | | 550. BY WHOM | | 551. IN PRESENCE OF | | 552. WITNESSES | | 553. CORONER | | 554. MEDICAL EXAMINER | | 555. PATHOLOGIST | | 556. ANATOMIST | | 557. BURIAL | | 558. CREMATION | | 559. OTHER | | 560. REMARKS | | 561. SIGNATURE | | 562. DATE | | 563. TIME | | 564. PLACE | | 565. BY WHOM | | 566. IN PRESENCE OF | | 567. WITNESSES | | 568. CORONER | | 569. MEDICAL EXAMINER | | 570. PATHOLOGIST | | 571. ANATOMIST | | 572. BURIAL | | 573. CREMATION | | 574. OTHER | | 575. REMARKS | | 576. SIGNATURE | | 577. DATE | | 578. TIME | | 579. PLACE | | 580. BY WHOM | | 581. IN PRESENCE OF | | 582. WITNESSES | | 583. CORONER | | 584. MEDICAL EXAMINER | | 585. PATHOLOGIST | | 586. ANATOMIST | | 587. BURIAL | | 588. CREMATION | | 589. OTHER | | 590. REMARKS | | 591. SIGNATURE | | 592. DATE | | 593. TIME | | 594. PLACE | | 595. BY WHOM | | 596. IN PRESENCE OF | | 597. WITNESSES | | 598. CORONER | | 599. MEDICAL EXAMINER | | 600. PATHOLOGIST | | 601. ANATOMIST | | 602. BURIAL | | 603. CREMATION | | 604. OTHER | | 605. REMARKS | | 606. SIGNATURE | | 607. DATE | | 608. TIME | | 609. PLACE | | 610. BY WHOM | | 611. IN PRESENCE OF | | 612. WITNESSES | | 613. CORONER | | 614. MEDICAL EXAMINER | | 615. PATHOLOGIST | | 616. ANATOMIST | | 617. BURIAL | | 618. CREMATION | | 619. OTHER | | 620. REMARKS | | 621. SIGNATURE | | 622. DATE | | 623. TIME | | 624. PLACE | | 625. BY WHOM | | 626. IN PRESENCE OF | | 627. WITNESSES | | 628. CORONER | | 629. MEDICAL EXAMINER | | 630. PATHOLOGIST | | 631. ANATOMIST | | 632. BURIAL | | 633. CREMATION | | 634. OTHER | | 635. REMARKS | | 636. SIGNATURE | | 637. DATE | | 638. TIME | | 639. PLACE | | 640. BY WHOM | | 641. IN PRESENCE OF | | 642. WITNESSES | | 643. CORONER | | 644. MEDICAL EXAMINER | | 645. PATHOLOGIST | | 646. ANATOMIST | | 647. BURIAL | | 648. CREMATION | | 649. OTHER | | 650. REMARKS | | 651. SIGNATURE | | 652. DATE | | 653. TIME | | 654. PLACE | | 655. BY WHOM | | 656. IN PRESENCE OF | | 657. WITNESSES | | 658. CORONER | | 659. MEDICAL EXAMINER | | 660. PATHOLOGIST | | 661. ANATOMIST | | 662. BURIAL | | 663. CREMATION | | 664. OTHER | | 665. REMARKS | | 666. SIGNATURE | | 667. DATE | | 668. TIME | | 669. PLACE | | 670. BY WHOM | | 671. IN PRESENCE OF | | 672. WITNESSES | | 673. CORONER | | 674. MEDICAL EXAMINER | | 675. PATHOLOGIST | | 676. ANATOMIST | | 677. BURIAL | | 678. CREMATION | | 679. OTHER | | 680. REMARKS | | 681. SIGNATURE | | 682. DATE | | 683. TIME | | 684. PLACE | | 685. BY WHOM | | 686. IN PRESENCE OF | | 687. WITNESSES | | 688. CORONER | | 689. MEDICAL EXAMINER | | 690. PATHOLOGIST | | 691. ANATOMIST | | 692. BURIAL | | 693. CREMATION | | 694. OTHER | | 695. REMARKS | | 696. SIGNATURE | | 697. DATE | | 698. TIME | | 699. PLACE | | 700. BY WHOM | | 701. IN PRESENCE OF | | 702. WITNESSES | | 703. CORONER | | 704. MEDICAL EXAMINER | | 705. PATHOLOGIST | | 706. ANATOMIST | | 707. BURIAL | | 708. CREMATION | | 709. OTHER | | 710. REMARKS | | 711. SIGNATURE | | 712. DATE | | 713. TIME | | 714. PLACE | | 715. BY WHOM | | 716. IN PRESENCE OF | | 717. WITNESSES | | 718. CORONER | | 719. MEDICAL EXAMINER | | 720. PATHOLOGIST | | 721. ANATOMIST | | 722. BURIAL | | 723. CREMATION | | 724. OTHER | | 725. REMARKS | | 726. SIGNATURE | | 727. DATE | | 728. TIME | | 729. PLACE | | 730. BY WHOM | | 731. IN PRESENCE OF | | 732. WITNESSES | | 733. CORONER | | 734. MEDICAL EXAMINER | | 735. PATHOLOGIST | | 736. ANATOMIST | | 737. BURIAL | | 738. CREMATION | | 739. OTHER | | 740. REMARKS | | 741. SIGNATURE | | 742. DATE | | 743. TIME | | 744. PLACE | | 745. BY WHOM | | 746. IN PRESENCE OF | | 747. WITNESSES | | 748. CORONER | | 749. MEDICAL EXAMINER | | 750. PATHOLOGIST | | 751. ANATOMIST | | 752. BURIAL | | 753. CREMATION | | 754. OTHER | | 755. REMARKS | | 756. SIGNATURE | | 757. DATE | | 758. TIME | | 759. PLACE | | 760. BY WHOM | | 761. IN PRESENCE OF | | 762. WITNESSES | | 763. CORONER | | 764. MEDICAL EXAMINER | | 765. PATHOLOGIST | | 766. ANATOMIST | | 767. BURIAL | | 768. CREMATION | | 769. OTHER | | 770. REMARKS | | 771. SIGNATURE | | 772. DATE | | 773. TIME | | 774. PLACE | | 775. BY WHOM | | 776. IN PRESENCE OF | | 777. WITNESSES | | 778. CORONER | | 779. MEDICAL EXAMINER | | 780. PATHOLOGIST | | 781. ANATOMIST | | 782. BURIAL | | 783. CREMATION | | 784. OTHER | | 785. REMARKS | | 786. SIGNATURE | | 78 | |
|---------------------|--|--------|--|--------|--|------------------|--|-------------------|--|---------------|--|-------------------|--|-------------|--|---------|--|-----------|--|------------|--|------------|--|-----------|--|----------|--|----------|--|----------|--|--------------|--|-----------|--|-----------|--|------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|-------------|--|----------------------|--|-----------------|--|---------------|--|------------|--|---------------|--|-----------|--|-------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|-------------|--|----------------------|--|-----------------|--|---------------|--|------------|--|---------------|--|-----------|--|-------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|-------------|--|----------------------|--|-----------------|--|---------------|--|------------|--|---------------|--|-----------|--|-------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|-------------|--|----------------------|--|-----------------|--|---------------|--|------------|--|---------------|--|-----------|--|-------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|-------------|--|----------------------|--|-----------------|--|---------------|--|------------|--|---------------|--|-----------|--|-------------|--|---------------|--|----------|--|----------|--|-----------|--|--------------|--|---------------------|--|----------------|--|--------------|--|-----------------------|--|------------------|--|----------------|--|-------------|--|----------------|--|------------|--|--------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|--------------|--|-----------------------|--|------------------|--|----------------|--|-------------|--|----------------|--|------------|--|--------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|--------------|--|-----------------------|--|------------------|--|----------------|--|-------------|--|----------------|--|------------|--|--------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|--------------|--|-----------------------|--|------------------|--|----------------|--|-------------|--|----------------|--|------------|--|--------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|--------------|--|-----------------------|--|------------------|--|----------------|--|-------------|--|----------------|--|------------|--|--------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|--------------|--|-----------------------|--|------------------|--|----------------|--|-------------|--|----------------|--|------------|--|--------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|--------------|--|-----------------------|--|------------------|--|----------------|--|-------------|--|----------------|--|------------|--|--------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|--------------|--|-----------------------|--|------------------|--|----------------|--|-------------|--|----------------|--|------------|--|--------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|--------------|--|-----------------------|--|------------------|--|----------------|--|-------------|--|----------------|--|------------|--|--------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|--------------|--|-----------------------|--|------------------|--|----------------|--|-------------|--|----------------|--|------------|--|--------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|--------------|--|-----------------------|--|------------------|--|----------------|--|-------------|--|----------------|--|------------|--|--------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|--------------|--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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0206 CERTIFICATE OF DEATH

Reg. Dist. No. 00202

| | | | | | | | |
|---|---------------------------|--|---------------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>AA Co.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA Co.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bristol</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bristol, Md</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Gus</u> Middle <u>Edward</u> Last <u>Wilkerson</u> | | | | 4. DATE OF DEATH Month <u>1</u> Day <u>30</u> Year <u>1960</u> | | | |
| 5. SEX <u>m.</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 10,</u> | 9. AGE (In years last birthday) <u>49</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Thomas Wilkerson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Priscella Wilkerson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT <u>Marion Wilkerson</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO <u>coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>54</u> , to <u>Nov 21</u> , 19 <u>60</u> ; that I last saw the deceased alive on <u>Nov 21</u> , 19 <u>60</u> , and that death occurred at <u>8:15</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Emil H. Lubin</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Luthan Md.</u> | | DATE SIGNED <u>1-30-60</u> | |
| PHYSICIAN'S NAME (Type) <u>acting Come</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2-2-60</u> | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY <u>Carriers</u> | | 22d. LOCATION (City, town, or county) (State) <u>AA Co. Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sawell</u> ADDRESS <u>Prince Frederick</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 4 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u> | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------|--|--------------------|--|-----------------|--|-------------------------|--|------------------|--|---------------|--|--------------------|--|------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | STATE OF BIRTH | | COUNTRY OF BIRTH | |
| JAMES EARL RAY | | MALE | | 35 | | JAN 5, 1928 | | MOBILE, ALABAMA | | MOBILE | | ALABAMA | | UNITED STATES | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | | COUNTRY OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | |
| APRIL 4, 1968 | | MEMPHIS, TENNESSEE | | MEMPHIS | | TENNESSEE | | UNITED STATES | | APRIL 4, 1968 | | MEMPHIS, TENNESSEE | | MEMPHIS | |
| TIME OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE OR INJURY | | ANATOMICAL SITE | | TIME OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | |
| 10:00 PM | | HEART DISEASE | | NATURAL | | CORONARY ARTERY DISEASE | | HEART | | 10:00 PM | | HEART DISEASE | | NATURAL | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | | COUNTRY OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | |
| APRIL 4, 1968 | | MEMPHIS, TENNESSEE | | MEMPHIS | | TENNESSEE | | UNITED STATES | | APRIL 4, 1968 | | MEMPHIS, TENNESSEE | | MEMPHIS | |
| TIME OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE OR INJURY | | ANATOMICAL SITE | | TIME OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | |
| 10:00 PM | | HEART DISEASE | | NATURAL | | CORONARY ARTERY DISEASE | | HEART | | 10:00 PM | | HEART DISEASE | | NATURAL | |

RECEIVED
 APR 10 1968
 BALTIMORE, MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0140

CERTIFICATE OF DEATH

Reg. Dist. No.

00203

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodland Beach</u> | | | |
| c. LENGTH OF STAY IN 1b <u>D.O.A.</u> | | | | d. STREET ADDRESS <u>Edgewater</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>P</u> Last <u>WILKINSON</u> | | | | 4. DATE OF DEATH Month <u>January</u> Day <u>6</u> Year <u>1960</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct. 9, 1914</u> | |
| 9. AGE (In years last birthday) <u>45</u> yrs. | | IF UNDER 1 YEAR Months <u>45</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | | IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Frezer box (const)</u> | | 11. BIRTHPLACE (State or foreign country) <u>Prince Geo. Col., Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>William Philmore Wilkinson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Stamp</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>220 07 5005</u> | | | |
| 17. INFORMANT <u>Mrs Jeannette A. Wilkinson- Wife- same as # 2</u> | | | | Address <u></u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) <u></u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 hr</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>January 6, 1960</u> to <u>January 6, 1960</u> , that I last saw the deceased alive on <u>Jan 6, 1960</u> , and that death occurred at <u>4:35 P.M.</u> from the causes and on the date stated above. Dead on arrival at hospital in ambulance | | | | | | | |
| ACTUAL SIGNATURE <u>S. Borssuck</u> | | | | M.D. <u>Ann S. Borssuck</u> <u>1876</u> | | | |
| PHYSICIAN'S NAME (Type) <u>S. Borssuck</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1-9-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> | | | | ADDRESS <u>Annapolis, Maryland</u> | | 24a. REC'D BY REGISTRAR <u>JAN 11 '60</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Charles S. K...</u> | | | | | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1910

Name of Deceased

Sex

Age

Usual Residence

Date

Place of Death

Cause of Death

Signature

Witness

Signature

Date

Signature

Date

Signature of Registrar

Date

Signature of Registrar

Date

Signature of Registrar

Date

Signature of Registrar

Date

Signature of Registrar

Date

Signature of Registrar

Date

Signature of Registrar

Date

Signature of Registrar

Date

Signature of Registrar

Date

Signature of Registrar

Date

Signature of Registrar

Date

Signature of Registrar

Date

0207

CERTIFICATE OF DEATH

Reg. Dist. No.

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|---|------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>A. A. Counts</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. Counts</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Skidmore</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Skidmore</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Hattie Williams</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1960</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Col.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-12-1879</u> |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Halda Williams Skidmore Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute myocardial infarction 1 day</u> DUE TO (b) <u>Hypertensive & arteriosclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebrovascular accident</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb 27, 1951</u> to <u>Jan 5, 1960</u> that I last saw the deceased alive on <u>Jan 5, 1960</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Faye W. Allen</u> M.D. | | ADDRESS (Street, city or town, state) <u>62 Cathedral St Annap, Md.</u> DATE SIGNED <u>1/7/60</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | |
| <u>Burial</u> | | <u>1-10-1960</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Broadneck</u> | | <u>Skidmore Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Keeseff, Anna, Md.</u> | | ADDRESS | |
| 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | |
| DATE <u>JAN 13 '60</u> | | <u>Arthur S. Hanna</u> | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

030

0208

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u> | | d. STREET ADDRESS <u>2628 Harlem Av.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Walter</u> First <u>Willoughby</u> Middle Last | | 4. DATE OF DEATH <u>1</u> Month <u>13</u> Day <u>19</u> Year <u>60</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 2, 1898</u> |
| 9. AGE (In years last birthday) <u>61</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipyard Worker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>North Carolina</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Jordan Willoughby</u> | | 14. MOTHER'S MAIDEN NAME <u>Hattie Stevenson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>216-01-6276</u> | |
| 17. INFORMANT <u>Hospital Records</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442X</u> DUE TO <u>Arteriosclerotic Cardiovascular Renal Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. DUE TO <u>Old Cardiovascular Accident</u> (c) <u>Hypostatic Pneumonia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic Pneumonia</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>11/25</u> , 19 <u>59</u> , to <u>1/13</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/13</u> , 19 <u>60</u> , and that death occurred at <u>10.00P</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Lionel McHenry</u> | | ADDRESS (Street, city or town, state) <u>Crownsville State Hosp, Md 1/14/60</u> DATE SIGNED | |
| PHYSICIAN'S NAME (Type) <u>Lionel McHenry, M.D.</u> | | <u>Crownsville State Hosp, Md 1/14/60</u> | |
| 22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1/17/60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Sutton Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Kingston N.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. W. 512</u> | | 24a. REC'D BY REGISTRAR DATE <u>JAN 22 '60</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Charles L. Hanna</u> | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

03 MAY 1963

RECEIVED

0502

CENTRAL AVE OF DEATH

0502

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CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH o. COUNTY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) 6 Dogwood Rd. | | d. STREET ADDRESS 6 Dogwood Rd. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) LIDA MYRTLE WILSON | | 4. DATE OF DEATH Month January Day 10 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 21, 1875 |
| 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR: Months 10 Days 10 Hours 1960 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | |
| 11. BIRTHPLACE (State or foreign country) Dunbar, Pa | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Aaron R. Dearth | | 14. MOTHER'S MAIDEN NAME Eliza J. Woodward | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. ? | |
| 17. INFORMANT Harriet Dearth Wilson, 6 Dogwood Rd. Annapolis, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 420.1 DUE TO (b) Coronary artery insufficiency DUE TO (c) Coronary artery insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH 3 minutes 5 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April , 19 58 , to Jan , 19 60 , that I last saw the deceased alive on Jan 10 , 19 60 , and that death occurred at 3:30 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE John L. Hedeman M.D. | | DATE SIGNED 1/10/60 | |
| PHYSICIAN'S NAME (Type) John L. Hedeman MD | | Annapolis, Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial | 22b. DATE THEREOF Jan. 11, 1960 | 22c. NAME OF CEMETERY OR CREMATORY Highland Cemetery | 22d. LOCATION (City, town, or county) (State) California, Pa. |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME | | 24a. REC'D BY REGISTRAR DATE JAN 13 '60 | |
| ADDRESS Annapolis, Maryland | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kram | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0209

CERTIFICATE OF DEATH

Reg. Dist. No.

27

1. PLACE OF DEATH

a. COUNTY

Anne Arundel

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write

RURAL and give nearest town)

Ft Geo G Meade

c. LENGTH OF STAY IN 1b

26 hrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore

d. NAME OF HOSPITAL (If not in hospital, give street address)

USA Hospital

d. STREET ADDRESS

1644 Warick Ave

e. IS RESIDENCE

ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

WARREN

Middle

G.

Last

WOMACK HR

4. DATE OF DEATH

Month

January

Day

23

Year

19 60

5. SEX

Male

6. COLOR OR RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ - DIVORCED ☐

8. DATE OF BIRTH

January 22, '60

9. AGE (In years last birthday)

25

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min. 25 25

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Warren G Womack

14. MOTHER'S MAIDEN NAME

Jannie Murphy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

INFORMANT

Address

Mother (as above)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Prematurity

776X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the under lying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

25 hrs

45 min.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While ☐ Nat while ☐ at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 23 Jan 19 60, to 19 60, and that death occurred at 2:55 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE

Matthew N. Harris

M.D.

USA HOSP FT GEO G MEADE, MD 23 Jan 60

PHYSICIAN'S NAME (Type)

MATTHEW N HARRIS, Capt., M.C.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

Cremation 25 Jan '60

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

Laboratory, U.S. Army Hospital, Fort Geo G. Meade, Md

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

B. M. Ellis, Capt. M.C.

BETTY M. ELLIS, MSC U.S. Army Hosp: Ft Geo G Meade

JAN 27 '60

Arthur S. Harris

2050191XV0

0080
0002
CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]
12. Place of registration: [illegible]

13. Name of informant: [illegible]
14. Address of informant: [illegible]
15. Signature of informant: [illegible]
16. Date of completion: [illegible]
17. Place of completion: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0210

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00208

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Same</u> b. COUNTY <u>Same</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Anne Arundel</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> | | | |
| c. LENGTH OF STAY IN 1b <u>One month</u> | | | | d. STREET ADDRESS <u>151 Riviera Drive (Riviera)</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>151 Riviera Drive</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Michael Daniel Zaucha</u> | | | | 4. DATE OF DEATH Month Day Year <u>January the 5th. 19 60</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>10/25/59</u> | |
| 9. AGE (In years last birthday) yrs. <u>2</u> | | IF UNDER 1 YEAR Months <u>11</u> | | IF UNDER 24 HRS. Hours <u>11</u> Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Carl Edward Zaucha</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Marylin Sue Wood</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Mr. C.E. Zaucha (father).</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory tract infection</u> <u>527.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>?</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Gustave H. Faubert</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | <u>1/5/60</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1-7-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN</u> | | 22d. LOCATION (City, town, or county) (State) <u>A.A.CO., MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond J. ...</u> | | | | ADDRESS <u>4001 RITCHIE HWY.</u> | | 24a. REC'D BY REGISTRAR <u>JAN 11 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Bp 2

2042 181XV5

